WHAT FACTORS PROMOTE OR INHIBIT ALTRUISM IN ORGANISATIONS: A CASE STUDY IN HEALTHCARE

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Award date:
2021

Awarding institution:
University of Bath

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A thesis submitted for the degree of Doctor of Philosophy

University of Bath

School of Management

February 2021

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ACKNOWLEDGEMENTS

I would like to thank those instrumental in helping me with this research. I would like to thank my supervisors Professor Yiannis Gabriel for his thought-provoking questions and challenges and Dr Andrea Herepath for her guidance and encouragement without which I simply would not have reached the end, as well as Professor Veronica Hope-Hailey for inspiring my entry into academia. I would like to thank my parents, Stan and Brenda, for supporting me through all my studies. I would also like to record my appreciation for colleagues, Caroline Clipson, Dominic O'Toole, Gareth Hadley, Safia Iman, Harry Cayton, Ros Searle and Douglas Bilton. Discussions with them about healthcare systems, professional ethics and theories of human nature all stimulated the research process. Thanks must also go to Lorna Fitzsimons and Baroness Margaret McDonagh, whose *Top Flight* leadership programme galvanised much of my thinking. Staff, speakers and colleagues on the programme were a huge support. Finally, I would like to thank Sara Allen, who held my hand during the times when I thought I would never finish.

ABSTRACT

The purpose of this thesis is to understand how altruism is shaped by organisational contexts and conditions. It takes the form of an in-depth case study of a hospital criticised in national inquiries for a lack of kindness and compassion towards patients. The literature indicated that altruism inside organisations would be affected by an organisation's internal relationships, cultural fabric, and activity architecture, as well as its members' personal helping resources and their behavioural practices. However, there was a significant gap in the literature for a model of how organisational contexts undermine altruism and encourage practices which inhibit it.

The findings from this study indicate that an organisational context will be unconducive to altruism when its emotional terrain is noisy, its culture or climate is threatening or uncertain, its relationships are characterised by friction, its users are diminished or denigrated and the balance between their helping needs and organisational helping resources is misaligned. Such factors can reduce organisational agents' personal resources with which to help users. In this case, four un-altruistic practices emerged out of such a context and the organisational conditions within it. These were agents' inattentiveness or indifference towards users, their avoidance of users, or their more active deterrence of users from seeking help. Combined, this reduced the extent to which organisational agents noticed, appreciated or assessed organisational users' welfare or need for help. Such practices are likely to distort professional practice and undermine good patient care as well as inhibit altruism.

The study contributes a new model to the literature setting out how these unconducive organisational conditions, reduced agent helping resources and un-altruistic practices might combine to erode the internal perception of user need and inhibit altruism. Further research is needed to test the validity of the proposed model and confirm the un-altruistic practices nested within it.

1 CHAPTER 1: INTRODUCTION

1.1 Introduction

The purpose of this thesis is to understand how organisations shape the altruistic emotions, actions or behaviours of their members. The author is interested in why people help each other. Why do we stop and perform an act of kindness one day but pass on by the next? The work takes the form of an in-depth study of a well-known case in healthcare. The case is that of Mid Staffordshire (Mid Staffs) Hospital, which was the subject of two major public inquiries into its treatment and care of patients (between 2005 and 2009). These inquiries identified a lack of kindness, compassion or concern for the welfare of patients. The work is intended to enhance understanding of how altruism operates in organisational settings and generate knowledge about which organisational factors promote or inhibit it by an exploration of this particular case.

Questions about why we do (or do not) help each other have preoccupied philosophers and theologians for millennia. The concept of 'a concern for the welfare of others' has a long-standing tradition in religion and philosophy (Berchman, 2005; Chilton, 2005; Davis, 2005; Habito, 2005; Homerin, 2005; Neusner and Avery-Peck, 2005). However, 'altruism', the term which delineates the academic space within which such concerns are studied, was coined relatively recently by sociologist August Comte (in his 1851 *Systeme de Politique Positive*) from the Latin 'alter' and 'u' meaning literally 'to this other' (Scott and Seglow, 2007). Since then it has become a classic sociological concept, operating as an antithesis to egoism (Bykov, 2017). At its simplest, altruism is indeed a concern for the welfare of others.

Man is a social animal whose ecological success is founded on a collection of highly developed social instincts, such as trust and co-operation (Ridley, 1996). That success is made possible by collective structures such as groups, organisations and societies. So, altruism must be considered in the context of a complex panoply of organisations

which have leverage over ‘when’, ‘where’, ‘how’ and ‘why’ we help each other. In that context, this work is intended to generate insight into the organisational aspects of altruism. Its main theoretical concern is how altruistic actions are shaped by organisational factors. It aims to answer the question of what factors promote or inhibit altruistic behaviour in organisational settings. The author is especially interested in situations where we would expect altruism to be present but perceive it to be absent. The academic value of this research will lie in an investigation of the less well-explored organisational aspects of altruism. Its practical value will lie in helping managers understand the role of altruism in organisational life. The intention is to expand existing theory on such matters.

1.2 Ethical Considerations and Personal Perspectives

The case being studied is extremely well-known. It resulted in active local and national campaigning by relatives of those treated at the hospital. It generated significant debate in the media and parliament, precipitated two national inquiries and prompted a number of related investigations by regulators and other agencies. The case provoked (and still provokes) strong views in the healthcare sector. Those involved are likely to feel strong emotions about the case and hold firm views about its causes or others involved. The main ethical considerations concern how individuals involved in such a charged (and contested) case are identified and data arising out of it is discussed. Patients died at the hospital. In these circumstances, it is important to write about such matters with compassion and show appropriate consideration for those involved, whilst maintaining the spirit of sceptical inquiry and critical challenge necessary to develop a full and balanced understanding of the case.

The approach a researcher adopts is inevitably shaped by their own values; values which they must manage in order to avoid undermining the credibility of their research (Saunders, Lewis and Thornhill, 2009). It is hard for human beings to divorce themselves from events. Values will, at the very least, affect how researchers interpret the events they are studying, which means that this research is likely to be

constrained by the author's own values. These were actually the impetus for this topic. As a child, the author was rescued by a bystander after falling off the wharf at high tide. Growing up in a small seaside town, altruism was highly visible, with lifeboat crew going out in winter storms at considerable danger to themselves and (indirectly) to their families. This author vividly remembers the night of the Penlee Lifeboat Disaster when the Solmon Browne went down with the loss of its entire crew. Care must be taken to prevent such life experiences from skewering the study.

1.3 Document Structure

This thesis is organised in five sections. Section I includes acknowledgements, an abstract and this introductory chapter. Section II sets out the Literature Review on altruism as a phenomenon. It has two chapters. The first of these, Chapter 2, explores the concept of altruism as an individual phenomenon. It indicates that an individual's personal, cognitive and affective traits might all have a bearing on their altruistic or helping behaviour inside organisations. The second of these, Chapter 3, explores the literature on altruism inside organisations. It indicates that the relationships inside an organisation, as well as its culture and arrangements for meeting demand, are likely to have a bearing on altruism. It indicates that altruism is likely to be promoted by practices of noticing, appreciating and assessing others' needs. However, it also delineates a gap in the literature for a model of how altruism is inhibited and what, if any, un-altruistic practices might be involved in such a process.

Section III sets out the methodology for the study. It has one chapter, Chapter 4. In this, the rationale for adopting a single case study in relation to the author's chosen questions is explained, as are pertinent methodological issues arising from that choice. In this chapter, the data sources are identified, the approach to analysis is set out and the results of a pilot study are summarised. The author's epistemological views and ontological perspective are also shared. An explanation of why this particular case is a suitable site for exploring the study's questions is also included.

Section IV sets out the findings. These are organised to focus on four aspects of the case which are most relevant to altruism as an organisational construct. These four aspects are a high level of emotional noise within the organisation (set out in Chapter 5), extensive conflict between its members (in Chapter 6), a demanding internal operational context (in Chapter 7) and un-altruistic practices which emerge as a result (in Chapter 8). Chapter 5 on emotional noise explores the distress of both organisational agents and users. Chapter 6 on conflict also includes an exploration of the diminishment of organisational users. Chapter 7 on demanding context explores the high strain on organisational agents as well as the low level of support to meet it. The four un-altruistic practices covered in Chapter 8 are inattentiveness, indifference, avoidance and deterrence.

Section V discusses these findings. It has one chapter, Chapter 9. This explores how the various factors identified in the findings, namely organisational conditions, reduced agent helping resource and un-altruistic practices may come together to suppress the visibility of user need and generate a high level un-noticing, which consequently inhibits altruism. The contrasting example of users is presented in this chapter to explain how altruism is promoted. This chapter also sets out the main contribution of the study, which is the construction of a model of the organisational inhibition of altruism. The research agenda for this model, and any limitations associated with the study undertaken to produce it, are presented at the end of the chapter.

SECTION II

2 CHAPTER 2: ALTRUISM AND THE INDIVIDUAL CONTEXT

2.1 An Introduction to Altruism

Altruism is a simple notion which has generated a considerable body of research. Despite its apparent simplicity, there are some significant challenges associated with studying it. One problem is ambiguity. Altruism may be a simple concept, but it is not necessarily a conceptually clean one. Analysis of it can be impaired by the inconsistent or contradictory use of overlapping terms and concepts in the literature. The main constructs, which are altruism, prosocial behaviour, organisational citizenship and the more colloquial term kindness, are often used interchangeably or indistinguishably. Associated concepts include those which denote other-orientated emotions, such as pity, compassion, sympathy, empathy, generosity and benevolence, or other-orientated actions, such as giving, sharing, helping or comforting (McGuire, 1994; Collett and Morrissey, 2007; Phillips and Taylor, 2009; Wittek and Bekkers, 2015).

In its simplest form, altruism is a concern for the welfare of others. August Comte, who coined the term (in his 1851 *Systeme de Politique Positive*) developed it from the Latin 'alter' and 'u' meaning literally 'to this other' (Scott and Seglow, 2007). Some theorists argue that altruism must benefit the 'recipient' as an end in and of itself in order to distinguish it from other forms of prosocial behaviour which can be egoistically (as well as altruistically) motivated (Bierhoff, 2008). Framed thus, altruism is defined as 'prosocial behaviour that has the ultimate goal of benefiting another person' (Bierhoff, 2008, p.179). Other theorists disagree, arguing that egoistic impulses which stimulate prosocial action do not necessarily undermine simultaneously occurring altruistic ones (Batson, 1987). This is an important distinction for a workplace environment where the boundaries between meeting the requirements of one's role and behaving prosocially may be blurred or overlap.

Perhaps the most comprehensive definition of altruism is that provided by Monroe, who describes it as:

> 'behavior intended to benefit another, even when doing so may risk or entail some sacrifice to the welfare of the actor. There are several critical points in this definition. First, altruism must entail action. It cannot merely be good intentions or well-meaning thoughts. Second, the goal of the act must be furthering the welfare of another. If another's welfare is treated as an unintended or a secondary consequence of behaviour designed primarily to further one's own welfare, the act is not altruistic. Third, intentions count more than consequences. If I try to do something nice for you, and it ends up badly or with long-term negative consequences for you, this does not diminish the altruism of my initial action. Fourth, the act must carry some possibility of diminution to my welfare.' (Monroe, 1994, p.862-3).

This definition makes the inter-active and bi-directional nature of altruism clear. It shows: that it requires action by someone (the giver or helper); that it must intentionally aid someone (the beneficiary or recipient); that the giver's intention is potentially more important than the outcome (the altruistic impulse or motivation); and that the giver must experience (or be exposed to) potential losses (a cost for helping). In line with this definition, most theories include the intentions which motivate people's actions, as well as the potential consequences for those being helped and the potential costs or rewards for those helping them (Dovidio, 1984). The common theme which unifies all such definitions is potentially costly other-orientated action in the face of need.

Another problem associated with studying altruism is the impact of the disciplinary matrix within with it is being studied: those symbolic generalizations, beliefs, values and exemplars which blinker scientific communities (Kuhn, 1996). Altruism's theoretical conceptualisation has been diversely shaped by the contradictory assumptions about human nature associated with different disciplines (Monroe, 1994; West, Griffin and Gardner, 2006; Clavien and Chapuisat, 2013). The development of a rounded and integrated understanding of it is impeded by this. Problematically, since much of the literature focusses on people's psychology, most of the models sit within the individual domain rather than the organisational one.

Unhelpfully, some important disciplines have neglected the subject. Altruism is substantially missing from management literature (Haynes, Josefy and Hitt, 2015). Its organisational aspects are underexplored, with limited attention paid to organisations themselves as structural factors underpinning it (Healy, 2004; Piliavin, 2009). Ironically, although altruism evolved out of sociological perspectives, sociologists have neglected the concept since the mid 20th century, creating a need to return to the subject through such lenses (Bykov, 2017).

Despite these limitations, some useful attempts to classify altruistic behaviour in organisational settings have emerged. Brief and Motowidlo (1986) developed a typology of 13 such behaviours which vary according to: whether they are directed at the organisation, its agents or customers; whether they are functional or dysfunctional in their impact on organisational effectiveness; and whether they are prescribed by organisational roles (or not). They define prosocial organisational behaviour as being:

> '…performed by a member of an organization,…directed toward an individual, group, or organization with whom he or she interacts while carrying out his or her organizational role, and…performed with the intention of promoting the welfare of the individual, group, or organization toward which it is directed.' (Brief and Motowidlo 1986, p.711).

By way of some examples, they explain that staff can provide services consistently or inconsistently in order to help users. Such variation could be detrimental or advantageous to the organisation. Alternatively, staff might provide additional personal services to colleagues, such as helping them with family matters. The functionality or dysfunctionality of such actions would, according to their typology, depend on the extent to which they erode capacity for prescribed or in-role activities. A potentially more costly action for staff which they identify is objecting to 'improper' organisational directives. In healthcare, that could mean objecting to targets which perversely affect patient care.

In one of the few attempts to theorise altruism as a purely organisational concept,

Szulc (2019) extends this typology further. Like Brief and Motowidlo (1986), Szulc identifies how altruism may be directed at colleagues, customers or the organisation itself (as stakeholders), may be directed to work-related or non-work related matters and be functional or dysfunctional in its effects. However, the model is extended to encompass the possibility that such behaviour may be characterised by deep or causal effort, be planned or spontaneous and arise from proactive or reactive initiative. The model is founded on the assumption that 'organisational altruism is benefitting a stakeholder as an end in and of itself', operating without the requirement for reciprocity (Szulc, 2019, p.51). However, although many definitions of altruism exclude reciprocity in this way, it is not without its advocates as a force for altruism (Trivers, 1971; Fehr and Gächter, 2002; Fehr, Fischbascher and Gächter, 2002; Nowak and Sigmund, 2005; Nowak, 2006).

In healthcare, altruism towards patients can be seen as an integral part of interpersonal professionalism (Van de Camp, Vernooj-Dassen, Grol and Bottema, 2004). Healthcare staff are seen to assume a duty of 'specific beneficence' towards patients and promote their welfare on that basis (Faust, 2009). However, even if one argues that much of their prosocial activity should (or does) fall within the boundaries of their role-related obligations or professional expectations towards clients, they can still go above and beyond their duties and experience costly loses for doing so (Montada and Bierhoff, 1991). There is evidence that they undertake extra role activity, work beyond contracted hours and go the 'extra mile' in professional matters (Davidoff, 2002). Altruism can also encourage approaches amongst medical or professional staff that help meet an organisation's common or overarching goals (Chahal and Mehta, 2010). However, altruism may also spur them to take actions which are personally threatening to their sense of self, their relations with peers or even the organisation itself. They may, for example, step outside of proscribed policies or procedures to provide a good service for their patients (Hyde, Harris and Boaden, 2013) or they might altruistically report mistakes and errors (Hung, Lee, Liang and Chu, 2016). The costliness of such choices is what makes them altruistic.

According to Feather and colleagues, hospital settings can be seen as sites which incorporate an extremely wide range of potentially prosocial actions (Feather, McGillis Hall, Trbovich and Baker, 2018). They consider working overtime, relieving others who need breaks or helping out with difficult patients and demanding obligations as altruistic. Alongside that, they identify a set of associated prosocial actions which include: conscientiously adhering to internal policies and procedures whilst avoiding short-cuts or workarounds; being a good sport, for example adopting welcoming stances, supporting new staff or eschewing negative attitudes; pursuing civically minded behaviours, such as joining in rounds, huddles or meetings; and behaving courteously. In the latter they encompass reporting errors or near misses and providing safe patient hand-offs which are more like obligations than courtesies.

Drawing on such expositions of healthcare professionals' altruistic or prosocial behaviour, one might conceptualise them as incorporating: extra-role activities, that is altruistic or prosocial actions not associated with one's job; discretionary in-role activities, that is additional action or effort, which might be altruistic by virtue of its scale and impact; or ultra-role activities for which one might be penalised by virtue of their non-conformity to the expectations of one's role amongst one's peers. Picking up on the point about costly choices, the actions Feather and colleagues deem prosocial could become altruistic under certain conditions. Where actions generate a significant personal cost for those undertaking them, yet they still choose to act, such behaviour could be considered altruistic. By way of example, if an employee supported a new staff member despite feeling extremely tired or highly stressed, it would enhance their peer's welfare whilst diminishing their own. It could be considered altruistic because of the physical or emotional costs involved. The extent to which it is altruistic, however, might also be affected by the intentions as well as the costs. If it was done to secure help in return, or enhance one's reputation, it would not be altruistic. If it was done purely to help a peer, it would be.

Despite the above two typologies, this field still lacks a comprehensive multi-disciplinary depiction of how altruism operates inside organisations which reconciles

the individual, contextual, social or relational influences identified in the general literature on the subject. For this reason, the study will pursue a multi-level, multidisciplinary approach, embracing the varied (and conflicting) disciplines in the literature. A working definition of organisational altruism will be:

> Actions (a) carried out by an organisation's members (b) intended to enhance the welfare of its agents or users (c) carrying the potential to diminish the welfare of those undertaking them, which (d) may be adopted as common practice and (e) may (or may not) be supported by internal contexts or conditions.

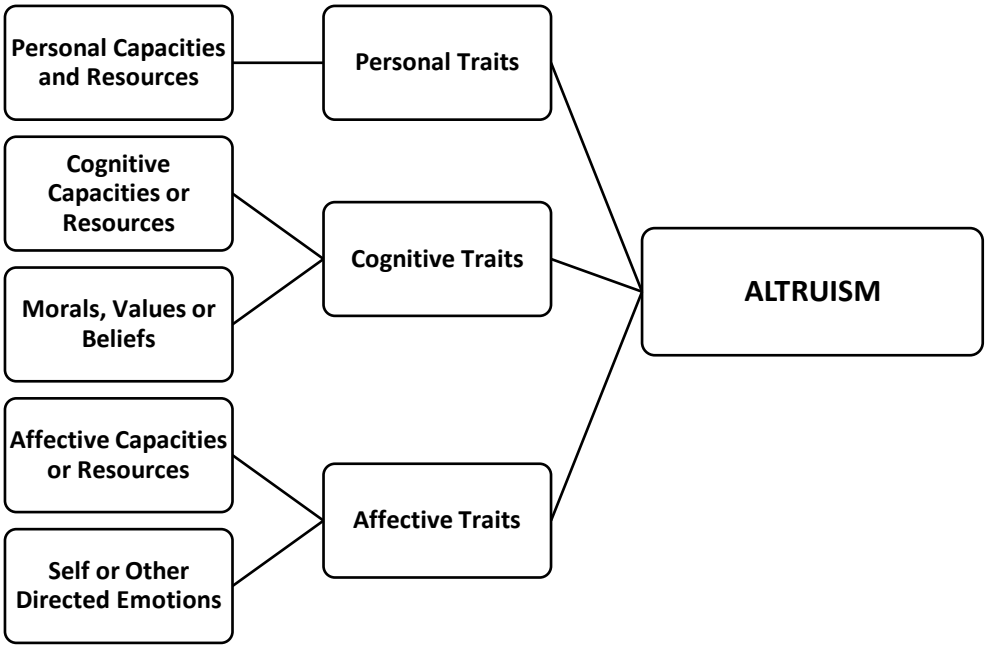
In this definition, agents are those responsible for operating organisations, their leaders, managers, staff and so on. Users are those depending on their services directly (their clients, customers, etc) or indirectly (i.e. friends, colleagues or relatives of users). The term members is used to denote both. This literature review is structured into two chapters. The rest of this chapter will briefly explore the individual traits or qualities which might influence organisational members' intentions or actions to address the welfare of another. These are relevant in so far as an organisation might promote or inhibit altruism by stimulating or suppressing such characteristics amongst its agents as a group. That is conceptualised as an organisation's effect on the collective internal quality or quantity of agents' helping capacity or resource. The second chapter in this section considers which organisational conditions might promote or inhibit altruism and what organisational or group-level practices might emerge as a result.

2.2 Altruism and the Individual

Altruism is carried out by individuals. As a human force, it can be generated, shaped or influenced by a wide range of individual personal traits, characteristics or qualities (Krebs, 1970; Dovidio, 1984; Piliavin and Charng, 1990; Batson and Shaw, 1991; Batson, Shaw and Slingsby, 1991; Eisenberg, Valiente and Champion, 2004; Penner, Dovidio, Piliavin and Schroeder, 2005; Scott and Seglow, 2007; Feigin, Owens and Goodyear-Smith, 2014). Put simply, it may be promoted or inhibited by 'who you

are' or 'how you feel' (Bierhoff, 2008, p.185). The rest of this chapter sets out those aspects which might influence the altruism of an organisation's members individually (see Figure 1). In particular, it will explore the personal traits or qualities which people bring to an organisation that might be strengthened or weakened by internal contextual influences to promote or inhibit altruism.

Figure 1: Altruism and the Individual



2.2.1 Personal Traits and Altruism

Some theorists argue that distinct and identifiable character traits promote altruistic or prosocial behaviour. Rushton, for example, identifies altruistic personalities as those with higher standards, moral modes of thinking or reasoning, empathy for others and an ability to see the world from their perspective (Rushton 1981, p.264). By way of an historical example, drawing on extensive interviews with Holocaust rescuers, Oliner and Oliner (1988) identify certain personalities, those characterised by traits of involvement, commitment, care and responsibility, as being more likely

to act altruistically (Oliner and Oliner, 1988).[1] Such an association has been confirmed in studies of moral obligation (Einolf, 2010). There is also some evidence that altruistic tendencies can be predicted, our peers know which of us are more likely to act altruistically (Rushton, Chrisjohn and Fekken 1981; Rushton 1981). However, proof of an altruistic personality per se is difficult to establish, as studies are methodologically unreliable and correlations with prosocial behaviour remain low (Krebs, 1970; Batson and Powell, 2003).

Despite this problem, a small number of specific personal traits emerge as significant. It appears our responses to others' suffering depends on how equipped we feel to respond, that is how we appraise our resources to help them or perceive our ability to cope with their needs (Goetz, Keltner and Simon-Thomas, 2010). There is a body of evidence showing that those who see themselves as more competent, capable or successful are more inclined to act prosocially (Berkowitz and Connor, 1966; Krebs, 1970; Isen 1970; Isen and Levin, 1972; Moore, Underwood and Rozenham, 1973; Piliavin and Charng, 1990; Penner et al., 2005). Personal agency, that is a sense of power to influence events, is also notably evident amongst the Oliners' altruists (Oliner and Oliner, 1988). This feature is important in care related contexts. For example, a study of NHS clinical (and non-clinical) staff working in varied settings, showed that employees' personal characteristics, their attitudes or abilities, were the most common reason given for acting prosocially (Hyde et al., 2013). Along similar lines, another study showed that nurses who see themselves as more efficacious behave more altruistically and deliver a higher quality of service (Lee, 2001). Conversely, caring professionals who evaluate themselves negatively tend to withdraw from others, experience negative emotions (such as fear) and even avoid service users to escape the stimulation of such states (Gibson, 2014). The importance of this for altruism as an organisational construct, is the extent to which internal environments foster feelings of efficacy or inefficacy amongst their staff, because it is an important helping resource.

[1] Conversely, un-altruistic constrictive personalities had traits of dissociation, detachment and exclusiveness.

Evidence also suggests that conscientious or agreeable qualities play a role in promoting prosocial actions inside organisations (Organ and Ryan, 1995; Podsakoff, Mackenzie, Paine and Bachrach, 2000; Podsakoff, Whiting, Podsakoff and Blume, 2009; Chiaburu, Berry, Li and Gardner, 2011; Podsakoff, Podsakoff, MacKenzie, Maynes and Spoelma, 2014). By way of example, studies show that conscientious and agreeable managers are more likely to value altruism, be motivated to act altruistically and respond to customers (Furnham, Treglown, Hyde and Trickey, 2016). The importance of such factors is also evident in studies of anti-sociality. In a meta-analytic review of the field, Jones, Lynam and Miller (2011) found that altruism had one of the largest negative relationships to antisocial behaviour or aggression. Such an effect is evident amongst public sector staff where altruistic orientations reduce aggression towards users (Mallia, Lazuras, Violani and Lucidi, 2015; Shi and Zhang, 2017). Considering such factors in healthcare settings, agreeableness might stimulate staff to provide additional emotional support to patients, while conscientiousness might stimulate them to point out mistakes or errors which cause harm. Taking the latter point on board, the importance of strong personal convictions or non-conformity are also indicated as an important requirement for morally rebellious acts of altruism such as rule breaking or whistleblowing (Dozier and Miceli, 1985; Monin, Sawyer and Marquez, 2008; Ambrose, Taylor and Hess, 2015; O'Connor and Monin, 2016).

Transposing individual traits which appear to promote altruism into an organisational context raises questions about how internal contexts or workplace conditions nurture or quell such qualities amongst their members. For those with strong personalities, the internal organisational context may have less influence on how they perceive situations (Dalal, Meyer, Bradshaw, Green, Kelly and Zhu , 2015). Conversely, personal characteristics may be undermined where an organisational context exerts a strong countervailing influence (Meyer and Dalal, 2009). The strength of such contexts will be influenced by the clarity and consistency of situational cues, the freedoms or constraints in place, and the likelihood of consequences (Meyer, Dalal and Hermida, 2010, p.125). While studies have shown

a high correlation between personality variables and altruism when such contextual constraints cannot be evaded, no significance remains when they can be avoided (Batson, Bolen, Cross and Neuringer-Benefiel, 1986; Carlo, Eisenberg, Troyer, Switzer and Speer, 1991; Bierhoff and Rohmann, 2004).

What this says about organisations is that their ability to reinforce, or override, any personal inclination for altruism will depend on the extent to which their constrictions can be evaded and the extent to which the personal qualities of their staff are strongly or weakly manifested. So, while there is sufficient evidence to indicate that altruism as an organisational construct needs to concede a role for individual traits and qualities, it should mainly focus on the organisational context's stimulation or suppression of those traits amongst its members which promote or inhibit altruism, as this will affect the level of internal helping resource.

2.2.2 Cognitive Traits and Altruism

Morals, values or beliefs are another important influence on individual altruism (Hauser, 2006; Haidt, 2007; Monroe, Martin and Ghosh, 2009; Van Veelen; 2009; Tomasello and Vaish, 2013). Krebs and Van Hesteren argue that altruism derives from systematic moral reasoning, with our prosociality determined by our level of moral development along a continuum ranging from complete egoism to absolute self-sacrifice (Krebs and Van Hesteren, 1994). However, linking altruism to morality has proven difficult, and while there is empirical evidence to support a relationship between moral reasoning and moral action, there is disagreement regarding the existence of specific associations with altruism itself (Blasi, 1980; Clavien and Chapuisat 2013, De Posada and Vargas-Trujillo, 2015). So, morality is likely to be a tricky concept to incorporate into any organisational model of altruism. Nonetheless, it appears worth pursuing.

Alternatively, some theorists have proposed more sequential moral decision-making processes to explain altruism. Schwartz, for example, proposes a role for

situationally specific personal norms or beliefs about helping which promote it. These norms or beliefs arise from internalised values and direct our altruism towards others in line with our expectations of our self and our perception of any responsibilities towards others as a result (Schwartz, 1973). Empirical evidence supports such a theory (Schwartz and Howard, 1981). The common point advocated by such approaches is that our altruism is rooted in specific values or beliefs which create expectations of our responsibility for altruism. The relevance of this to organisational contexts is that members may bring certain personal views about their responsibilities towards others with them, which might affect how they see their responsibilities towards others inside the organisational context. For altruism as an organisational construct, any conflict between these two moral drivers, that is personal responsibilities and organisational responsibilities, would be important.

Other theorists give even more primacy to our views or beliefs about those who need aid in their attempts to explain altruism. Drawing on detailed studies of Holocaust rescuers, Kirsten Monroe identified a unique view of others amongst altruists, a perspective in which they see people as connected by a common humanity, believe that everyone has value, with no one group better than another, and consider people as just people (neither good nor bad) (Monroe, 1996). What is especially noticeable amongst those with this view is not simply their disregard for costs, but their lack of a cost-reward matrix altogether in the face of need (Monroe, Barton and Klingemann, 1990). Monroe's theory extends the ethical values identified by the Oliners in the same very extreme context (Oliner and Oliner, 1988). However, it is difficult to validate.[2] By way of a counterpoint, one well-evidenced other-orientated view is Melvin Lerner's just-world-hypothesis which indicates that we believe our world is well-ordered and that people get what they deserve (Lerner and Miller, 1978).

[2] For example, a series of ten studies indicate that identification with all humanity is less about the presence of values or morality, and more about the absence of ethnocentrism (McFarland, Webb and Brown, 2012).

According to Lerner, when we see recipients being harmed we can restore balance (i.e. make the world fair again) by compensating those harmed, punishing perpetrators, or even distorting our perception of harm. We achieve the latter by devaluing the victim or lessening the perceived harmfulness of actions. There is substantial empirical evidence that individuals do indeed believe this view, and that as well as reducing (or recompensing) a victim's suffering to support their belief, they might even distort their perception of that suffering as deserved (Simmons and Lerner, 1968; Lerner and Lichtman 1968; Lerner and Miller, 1978; Dovidio, 1984). Pertinently for organisations, the presence of such beliefs internally, or their promotion by organisational contexts and cultures, could promote or inhibit altruism, especially towards customers or clients. As an organisational construct, altruism needs to take account of how such beliefs are manifested, normalised and collectivised by internal contexts or conditions.

A number of theories have emerged which indicate a more pooled role for morality, whereby our views or values combine with other factors which promote responsiveness to suffering in order to motivate altruism**.** Drawing on a study of staff working in public services, Szulc (2020) for example, identifies 'good soldiers' inside organisations who combine motives which predispose them to treat others well with personal traits which enable them to capitalise on those motives. According to this model, our motives incorporate concern for other colleagues or customers and generalised beliefs about reciprocity, but no expectation of benefit for helping them. Relevant personal characteristics include discretion, self-sacrifice and initiative. This model neatly responds to some of the cognitive factors in the literature concerning what people believe is morally appropriate but adds them together with those personal traits in the literature which may be necessary to induce or enable them to act on such beliefs. Placing such a model into healthcare, a nurse who stays after their shift to reassure a patient would be using their initiative to decide that support is needed, exercising their discretion to provide it and sacrificing their personal time to do so. No benefit might be expected, but such an action would probably be contingent upon their beliefs about patients. A just-world perspective might see the

patient as deserving (or undeserving) of aid, while a common humanity view might impel action even if the patient is demanding. The model has strength in its capacity to explain how altruism might arise from an interplay of moral beliefs and personal qualities.

Transposing views or values into an organisational context raises questions about the potential interaction between organisational members' personal beliefs and the prospect of broader organisational views or values. Individual personal norms, values or attitudes are generally shown to promote altruistic behaviour inside organisations (Organ and Ryan, 1995; Podsakoff et al., 2000; Podsakoff et al., 2009; Chiaburu et al., 2011; De Geus, Ingrams, Tummers and Pandey, 2020). In healthcare, the most prominently identified sets of values amongst employee populations are: altruism, including related concepts such as compassion, caring and empathy; equality, which includes beliefs about dignity, respect and justice; and capability or competence (Moyo, Goodyear-Smith, Weller, Robb and Shulruf, 2016). Importantly, healthcare professionals see their other-orientated values as a source of motivation. In a comprehensive study of prosocial organisational behaviours amongst NHS staff for example, prosocial values towards patients (or colleagues) were the most commonly given reasons for helping, by 21 percent and 11 percent respectively (Hyde et al., 2013). However, only 13 percent of those studied actually reported acting prosocially.[3] This indicates that although professionals may see their own personal values as playing a role in promoting prosocial behaviour, they might not actually be acting in accordance with them. For organisations, this raises the question of why employees might not act upon any prosocial orientations which they hold towards the organisation, its agents or users.

This might be explained by competing values. Behaviour inside organisations is shaped by a threefold moral dimension comprising employee values, management

[3] Notably, in this study, prosocial values towards patients were the best predictor of staff helping peers deliver services or providing those services flexibility to benefit patients, including operating outside of organisational policies or procedures to do so.

values and organisational values (Arieli, Sagiv and Roccas, 2020). Or there may be other broader occupational or contextual moderators. For example, Treviño and colleagues found evidence of an association between the nature of one's own moral judgement and the moral quality of one's workplace environment, with differing levels of moral reasoning evident in different professions, tiers or ages and stages of life at work (Treviño, Weaver and Reynolds, 2007). Evidence of such variations can be seen in a study of nursing staff, which found that moral judgment was a unique and distinct predictor for altruism, but only amongst older staff (Wagner and Rush, 2000). For the construct of organisational altruism, this raises the issue of how individual and organisational values align to endorse (or undermine) altruistic actions or prosocial behaviour. It also indicates the need to ascertain which organisational contexts or conditions might normalise acting in accordance with prosocial values and which might legitimise eschewing them.

Morality models exhibit a high level of overlap. Krebs and Van Hesteren's integrative model, for example, incorporates, embraces or foreshadows a range of altruistic forms explored by other theorists.[4] They identify mutual or conscientious altruists, echoing the importance of duty and responsibility outlined in Schwartz's (1973) model of personal norms. Their mutually motivated altruists also reflect the critical obligation of give and take which is enshrined in theories of reciprocal altruism. Their conscientiously motivated altruists, those who aid others as a result of their personal scruples or responsibilities, also fit with theories of personality. Their integrated or autonomous altruists resemble Batson's (1987) empathically motivated altruists, who help on the basis of concern for others. Their autonomous altruists, those who engage on the basis of high-level internalised values, resemble the Oliners' ethically

[4] Individuals progress through eight stages of altruistic attainment: *'undifferentiated affective responsiveness'* at stage zero (e.g. reflexive behaviours such as smiling); '*egocentric accommodation'* at stage one (e.g. responding to others distress in order to reduce one's own); *'instrumental co-operation'* at stage two (e.g. engaging in exchanges to benefit oneself); *'mutual altruisms'* at stage three (e.g. responding to others on the basis of shared roles and obligations); *'conscientious altruism*' at stage four (e.g. responding to others on the basis of responsibility and conscience); *'autonomous altruism'* at stage five (e.g. responding to others on the basis of high internalised values); '*integrated altruism'* at stage six (e.g. feeling a sense of oneness with others); and *'universal self-sacrificial love'* at stage seven (driven universal love or a sense of oneness with the world), (Krebs and Van Hesteren, 1994, p.120/121).

motivated actors. Finally, their integrated altruists, those who engage based on a feeling of oneness with other people, appear to resemble Monroe's (1996) common humanists.

The vital common feature that one can synthesise from these similarities is that one's moral, ethical or cognitive stance towards oneself, in conjunction with one's moral, ethical or cognitive stance towards others, will influence one's altruism. Considering this in an organisational context raises questions about the extent to which members internally both believe others are deserving of aid and see themselves as responsible for providing it. Should such a stance be common inside an organisation, altruism is likely to be promoted. Clearly, the opposite orientational pattern would inhibit it. The main issue for altruism as an organisational construct, however, is how organisational contexts or conditions might contribute to the creation or suppression of such orientations. As sources of altruistic motivation for altruism, they could be conceptualised as an internal ethical resource which might be nurtured or restrained by organisational forces.

Moving on from what we think to how we think, our mental capacity to discern or process need is also important for altruism. This encompasses our ability to see situations from the position of another, understand their thoughts and feelings and make assessments or attributions about their behaviour (or our own) (Schroeder, Penner, Dovidio and Piliavin, 1995). Reliable relationships have been established between our ability to take the view (or perspective) of another and our altruism towards them (Krebs and Russell, 1981; Underwood and Moore, 1982; Galinsky and Moskowitz, 2000; Longmire and Harrison, 2018). Though recently the importance of 'getting' rather than simply 'taking' the perspective of another has been stressed (Eyal, Steffel and Epley, 2018). Moreover, perspective-taking itself may be moderated by the nature of the perspective taker, the nature of the target and any attributions made about them, as well as the orientation of relationships between the two (Ku, Wang and Galinsky, 2015). One can assume that the level of altruism inside an organisation will be affected by the collective cognitive capacity (or

resource) for perspective-taking prevalent amongst staff. More importantly for altruism as an organisational construct, however, might be the role that an organisational context plays in stimulating or suppressing perspective-taking as a collective resource, or the internal distractions which might reduce the practice of it.

Taken altogether, there is sufficient evidence to indicate that altruism as an organisational construct needs to concede the possibility of a role for individual moral traits, qualities or cognitive resources. However, it is unlikely that morality will be enough to promote altruism on its own. Addressing this limitation, some theorists argue that feeling and morality are closely intertwined in promoting prosocial treatment of others (Neiman, 2009; Phillips and Taylor, 2009). In their kindness-based model for example, Canter and colleagues (2017) extend the concept of morally motivated altruism. They argue that everyday prosocial acts come from a combination of benign tolerance, principled pro-action and empathic responsivity (Canter, Youngs and Yaneva, 2017, p.17).[5] Their benign tolerance, which adopts a live and let live stance, is somewhat akin to Monroe's (1996) conceptualisation of common humanity in stressing acceptance of others. Their principled pro-action, which is characterised by proactive and honourable behaviour towards others, and stresses what we owe them, is akin to equity theories, such as the just-world hypothesis. Importantly, however, they argue that such moral or ethical motivations must be complemented by a personal, reactive and emotional consideration of other's feelings. That is, an empathic concern for them. The model suggests that altruism can be better explained by balancing the moral elements evident in rational or cognitive theories of altruism with the emotions evident in affective theories of altruism. These will be considered next.

[5] Three factors together generate core kindness, which is: 'a tendency towards active gestures motivated by genuine warm feelings for others. There is no expectation of reward or social approbation,' (Canter et al. 2017, p.17/18).

2.2.3 Affective Traits and Altruism

There is a substantial body of evidence that positive moods, states or emotions promote altruistic or prosocial behaviour, as well as some indications that negative ones have the capacity to inhibit it (Manucia, Baumann and Cialdini, 1984; Dovidio, 1984; Eisenberg and Miller, 1987; Carlson and Miller, 1987; Carlson, Charlin and Miller, 1988; Eisenberg and Fabes, 1990; Eisenberg, 2000; Cuff, Brown, Taylor and Howat, 2014). Emotions function as proximate mechanisms which support altruism or reciprocity between people, with empathy motivating givers to help, anger motivating them to harm those who do not help and guilt motivating them to help injured parties (De Waal 2008; Kurzban, Burton-Chellew and West, 2015).[6] Employees who experience positive moods at work are more likely to engage in both prosocial behaviour prescribed by their roles, such as customer service, as well as extra-role altruism (George, 1991). Clearly, emotions are an import factor.

Critically, certain moral, social or other-orientating emotions, such as empathy, sympathy and compassion, enable us to enable us to feel 'as' others do, 'with' or 'for' them, stimulated by an awareness of their suffering (Wispé, 1986; Cassell, 2002; Haidt, 2003; De Vignemont and Singer, 2006; Tangney, Stuewig, and Mashek, 2007; Singer and Lamm, 2009; Lamm and Singer, 2010; Bernhardt and Singer, 2012).[7] The theory that our empathic concern for others arises from an imbalance between their ideal and actual state and generates altruistic motivation to alleviate their distress, has been widely tested and endorsed (Batson, 1987; Batson and Shaw, 1991; Batson, Shaw, and Slingsby, 1991; Batson and Powell, 2003; Bierhoff and Rohmann, 2004; Batson, Ahmad and Stocks, 2004; Feldman Hall, Dalgleish, Evans and Mobbs, 2015). The common factor is that these emotions orientate us towards others and enable

[6] De Waal defines directed altruism as 'helping or comforting behaviour directed at an individual in need, pain or distress' in response to situational triggers (De Waal 2008, p.281).

[7] Haidt defines moral emotions as: 'those emotions that are linked to the interests or welfare either of society as a whole or at least of persons other than the judge or agent,' (Haidt 2003, p.853). Other-suffering emotions are empathy, sympathy and com passion. The other emotions are other-condemning emotions of anger, contempt and disgust; self-conscious (or self-condemning) emotions of shame, embarrassment and guilt; and other-praising emotions which include gratitude and self-elevation (stimulated by acts of moral beauty such as sacrifice.

us to enter into or appreciate their suffering to varying degrees. What this means for organisations is that the general emotional state of their members is likely to affect altruism. At a group level, that could have implications for altruism as an organisational construct. It indicates that emotional or affective capacity will be an important organisational resource for promoting prosocial behaviour.

In their model of altruism, McGaghie and colleagues propose that healthcare professionals possess a compassionate core from which altruistic acts emanate, which they bring into healthcare with them and which helps them maintain their enthusiasm for prosocial action over the course of their working life (McGaghie, Mytko, Brown and Cameron, 2002). This core combines cognitive and affective capacities with moral resources and social skills. The latter, which they say incorporates an awareness of self and other, can be conceived of as a form of perspective-taking. They also argue that there is a layer between one's compassionate core (from which altruistic acts emerge) and the external world (where altruistic acts are discharged) which is comprised of discernment and judgment about the appropriateness of altruistic responses. Importantly, within the model, a doctor who misjudges the proper level of altruistic behaviour in professional situations might either over-extend themselves, or under-respond to another's needs. This model elegantly integrates a number of individual level factors into the concept of a compassionate core but it lacks an explanation of how specific organisational features might nurture (or supress) behaviour in line with that core. Pertinent for altruism as an organisational construct, is the question of how internal contexts or conditions encourage employees (as a group) to over-extend themselves or under-respond to patients by means of its impact upon their compassionate core.

Although affective explanations of altruism indicate that emotions which connect us to another's suffering can indeed promote altruism, there is also evidence that they are insufficient to do so on their own, can be countermanded by other factors, and may even be deliberately dampened (Slote, 2007; Singer and Lamm, 2009; Cuff et al., 2014). Correlations between empathic concern and specific prosocial behaviours

(such as consoling the distressed) can be weak Einolf (2008). The reason for this may lie in the context within which such emotions have been generated. Pulcini (2017) argues that affective states are morally neutral prompting differing (positive or negative) emotions, depending on who is the subject of such emotions and what our relationship with them is. The missing element in purely affective explanations of altruism is that one must care how another feels (not simply have feelings about them) and be concerned about what happens to them as a result (Jensen, Vaish and Schmidt, 2014). You must possess other-regarding concerns which are aligned with your other-suffering feelings if you are to act. Those might come from one's moral beliefs about responsibilities towards others discussed in the previous section. For altruism as an organisational construct, however, this means that simply nurturing employees' compassion towards colleagues or clients is unlikely to generate widespread altruism or prosociality on its own. That is a clear problem for NHS healthcare contexts, where much has been made of compassion as a solution to the neglect of patient welfare.

Importantly, the influence of affect depends on what it instigates us to think about (Isen, 2008). From a comprehensive review of the evidence for moods' influence on altruism or helping behaviour, Dovidio (1984) concluded that good moods appear to stimulate helping through their power to shape our attention to others, our perception of their needs (in relation to our own), our sense of 'we-ness' with them, our feelings of efficacy about helping them and the importance of any rewards involved in doing so, all of which might increase our arousal, elevate our empathic concern, lessen the cost of helping or increase the rewards for doing so. Although there is less evidence to support it, Dovidio went on to speculate that negative moods or states might inhibit altruism by means of lessening our attention to others, lessening our perception that their needs are important (compared to our own), or heightening our own sense of helplessness (Dovidio, 1984). Synthesising Dovidio's main themes, there appear to be moral, relational, tonal and attentional dimensions moderating the influence of our moods and emotions upon altruism. What that means is that how we perceive or assess such emotions is a factor.

Picking up on the tonal and attentional variables, Weyant (1978) proposes a mood-related model of altruism which might explain how such effects would work. Drawing on a study which examined the costs and benefits of helping, Weyant found that feeling negative might promote helping when it is highly beneficial (but not very costly) to do so, but inhibit it when it is both costly and unbeneficial (Weyant, 1978).[8] So, if one feels depleted, staying on beyond one's shift might be unlikely because it would further erode one's energy without recompense. It would be costly and unbeneficial. However, the rewarding gratitude of one's colleagues might change that. It would still be costly, but there would now be a benefit. Along related lines, studies have shown that the way in which our attention is directed (to ourselves or others) and applied to either party (positively or negatively) does indeed have a bearing on our helpfulness (Wegner and Schaefer, 1978; Thompson, Cowan and Rosenhan, 1980; Rosenhan, Salovey and Hargis, 1981; Rosenhan, Salovey, Karylowski and Hargis, 1981).[9] So, an issue for organisations is the extent to which internal contexts or conditions direct employees' attention (as a group) in ways that moderate, increase or reduce their emotional propensities to act altruistically. Altruism as an organisational construct may, therefore, need to consider an organisation's direction of its member attention to their own situation or to others' in positive or negative ways. Doing so might explain poor quality care as easily as it might explain altruistic action or inaction.

Another significant problem with affective influences on altruism is that the very emotions which enable us to detect other-suffering can also prompt us to ignore or neglect it. This may be a result of the nature or tenor of the emotions aroused. Cialdini and colleagues argue that when we see others suffering we experience

[8] The study examined the costs and benefits of helping under states of positive, negative or neutral mood in situations in which subjects were asked to collect donations for a charity (i.e. high benefit) or a community activity (i.e. low benefit) through high cost (door to door) or low cost (seated at a desk) . Weyant found that positive mood generated more helping than negative mood, and that negative mood generated more helping than neutral mood, when the benefits were high, but the costs were low.

[9] Rosenhan, Salovey, Karylowski and Hargis (1981) go on to hypothesise that the main psychological purpose of emotions is to increase our attention and amplify our cognition, with the power to narrow our attention and anchor it onto those stimuli that provoke the emotion, what they call 'attentional anchoring'.

negative emotional states of arousal, in particular sadness, which we act on in order to alleviate (Baumann, Cialdini and Kendrick, 1981; Cialdini, Schaller, Houlihan, Arps, Fultz and Beaman, 1987). However, the evidence for this is weak (Dovidio, 1984; Piliavin, 2009). More usefully, Batson distinguishes between personal distress, that is feeling anxious, upset, disturbed, distressed or perturbed, which can prompt egoistic motivation to reduce one's own feelings about others' suffering, and empathic concern, that is warmth, compassion, sympathy, soft-heartedness or tenderness, which can prompt altruistic motivation to relieve their distress (Batson, 1987). Again, the former might be seen as directing one's attentions to one's own distress in a negative way, while the latter would be seen as directing one's attention to others' distress in a positive way. Considering affective elements at an organisational level raises questions about the tenor of the internal emotional environment. As a construct, organisational altruism may need to allow a significant role for the internal emotional climate, as well as carefully consider which contextual factors or conditions are most likely to stimulate positive emotions that are conducive to altruism or prompt negative ones which are unconducive to it.

Considering this point further, organisations themselves are intensely affective environments, in which some feelings appear to be widely expressed, while other emotions seem to go under the radar (Clancy, Vince and Gabriel, 2012). The extensive expectation, and potentially draining effect, of emotional labour at work, is well evidenced (Kessler, Heron, Dopson, 2015; Grandey and Melloy, 2017). Experiencing significant emotional pressures generates an additional cognitive load for staff who must manage or attend to the sources of such emotions (Elfenbein, 2007). Pressured conditions inside organisations can reduce the emotional bandwidth which is needed to induce those feelings for others which would prompt empathic responses (Lilius, Kanov, Dutton, Worline and Maitlis, 2012). Working in professional contexts can induce very negative emotions, placing staff in tense and vulnerable states which undermines such feelings (Grant, Lavery and Decarlo, 2019). The emotional fatigue which contexts create affects our ability to manage our emotions, can reduce our other-suffering capacity and may even increase our

aversive affective responses to their pain (Goetz et. al, 2010). Moreover, employees have to manage their emotions to match their organisation's affective climate or culture (Mikolajczak, Tran, Brotheridge and Gross, 2009). What all this suggests is that a negative internal emotional climate may play a significant role in inhibiting altruism by means of its dilution of collective affective capacity or resource. However, some emotions may be easier to distinguish within this process than others.

Sharing the distress of others is an especially challenging feature of working in healthcare, which can generate substantial mental, emotional or psychological costs and result in staff actively managing their emotions to avoid sharing in others' suffering (Theodosious, 2008; Faust, 2009; Singer and Klimecki, 2014; Cocker and Joss, 2016). Problematically, emotions may become maladaptive, stimulating organisational agents to adopt inappropriate behaviours or emotional responses in attempts to manage them (Mikolajczak et al, 2009). Being required to show emotions we do not feel, can be managed by physically or psychologically withdrawing from situations (Stets and Turner, 2008). Thus, employees might take steps to regulate any emotional demands upon them by deploying their attention in ways which protect them from having to experience these at all (Gross, 1998; Gross, 2008; Gross, 2013). This may be done deliberately (or reflexively) and consciously (or unconsciously) to control which emotions they feel, or when or how they feel them, in order to increase or decrease the negativity they feel about others' distress (Gross, 1998).[10] By way of example, from a study of call centre employees experiencing significant emotional demands in the workplace as a consequence of emotionally demanding customers, Do Bonfim and Gondim (2009) identified both cognitive

[10] We may regulate our emotions by: selecting which situations we do (or not) enter, for example avoiding particular people, places or objects; modifying the situations we do enter and thus changing the emotional impact they have on us; deploying our attention in a particular way within situations (for example, allowing ourselves to be distracted from a situation, concentrating on something else extraneous to it or ruminating on particular aspects or feelings); cognitively changing a situation or how we appraise it; and then modulating our responses accordingly (Gross, 1998; Gross, 2008). Changing situations enables us to frame them in a way which gives us permission to changes our emotional responses (Gross, 2013).

strategies regarding their beliefs, attributions and so on, as well as behavioural strategies, such as avoidance. Avoidance is particularly likely in those situations where we know that we will be asked to help others and doing so will be costly (Batson, Shaw and Todd, 1994). Along such lines, staff in healthcare settings have been shown to avoid becoming too involved in their clients' situations to protect themselves from the emotional intensity of such work (Ostadhashemi, Arshi, Khalvati, Eghlima, Hamid and Khankeh, 2019). They may deliberately avoid the development of fellow feeling for patients (Faust, 2009).

Even more problematically, because we have an optimal range of distress we can tolerate, inside of which we are responsive to others' needs, but outside of which we become absorbed in our own, organisational members might experience an over-arousal effect which severely erodes capacity for altruism (Hoffman, 1981a; Hoffman, 1981b). Importantly for a study of healthcare, such an effect is pronounced among professional employees who are unable to lessen others' distress, or curb it to a manageable level (Hoffman, 2008). Behaviours associated with this effect include: directing one's attention to oneself and focussing inwardly; adopting means to lessen one's sense of arousal or reduce one's empathic distress, for example not looking at people, leaving or moving away from them; and even manipulating one's cognition of situations, such as thinking of other matters to distract oneself (Hoffman, 1981a; Hoffman, 2008). Importantly for this study, healthcare is a sector in which patients' emotions are likely to be both powerful and pervasive, so staff may be unable to assuage or curb them, as well as unable to absorb or cope with them.

Given this structural arrangement of the sector, it is important to acknowledge that the effect of patient distress upon professionals can be intense and extreme. Clinicians who work with trauma patients, for example, report significant symptoms and disturbing cognitive disruptions, such as nightmares (Hoffman, 2008). In a real-life study of observers' responses to terminally ill patients' video testimonies, for example, Preston, Hofelich and Stansfield (2013) found that distraught patients

generated more empathic concern or personal distress than other types of patient, but also more horror. Problematically, there is a body of evidence from neuroimaging studies which shows that empathising with others' pain activates the same pathways as those stimulated by one's own pain (Singer and Klimecki, 2014, Decety and Lamm, 2009). Thus, one can speculate that healthcare professionals are being constantly exposed to other-related pain which is tantamount to experiencing their own. This may explain why physicians are shown to rate pain and unpleasantness much lower than others do, actively reducing their perception of distress or dampening their fear and alarm about suffering (Decety, Yang and Cheng, 2010).[11] It may be considered an inevitable practice, given the structural arrangement of the industry.

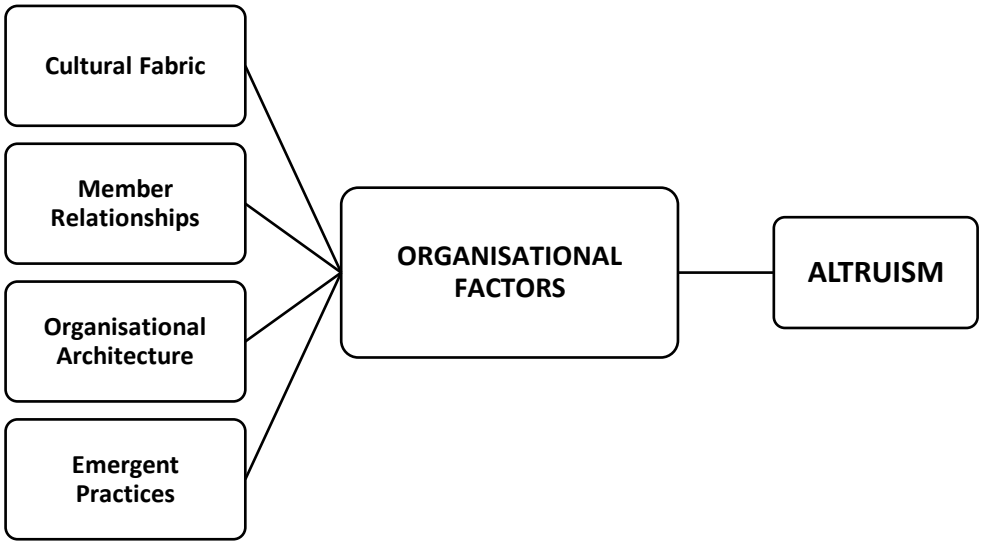
What this means for altruism as an organisational construct is that in those sectors where emotional distress is extreme in nature, or widespread, altruism is likely to be inhibited by means of its impact on affective capacity or resource. This is a structural feature which will vary from sector to sector, depending on the pain, suffering and distress of the organisational user group, and the expectations of the organisational agent group to collectively manage that distress or cope with it. Considering such matters at an organisational level raises questions about the extent to which this feature might reduce an organisation's internal affective helping capacity or stimulate practices amongst its members which help them navigate the emotional terrain but reduce their inclination to help others. This brings us to a consideration of the organisational context.

[11] Decety et al.,(2010) go onto speculate that whilst this lessens feelings of which would undermine their ability to work effectively, it also undermines helping action, by leading them to underestimate the importance of the pain which others' feel.

3 CHAPTER 3: ALTRUISM AND THE ORGANISATIONAL CONTEXT

Although altruism is a human force, undertaken by individuals, it is also grounded in specific contexts where help is needed. As a contextualised phenomenon, it is created and shaped by potential givers' situational circumstances. The environmental factors which influence altruism include: potential helpers' situated awareness, that is the extent to which their contexts allow them to see someone's need for help; their situated capacity, that is the helping resources available to them in a particular context; the impact of providing any help, including any costs or benefits of helping in particular situations or contexts; as well as the characteristics of those who need help and any situational social signals about helping them (Krebs, 1970; Dovidio, 1984; Piliavin and Charng, 1990; Penner et al., 2005; Scott and Seglow, 2007; Bierhoff, 2008; Feigin et al., 2014). This chapter explores the potential influence such factors wield inside an organisation's context. There are sections covering culture, relationships and organisational architecture (see Figure 2).

Figure 2: Organisational Context and Altruism



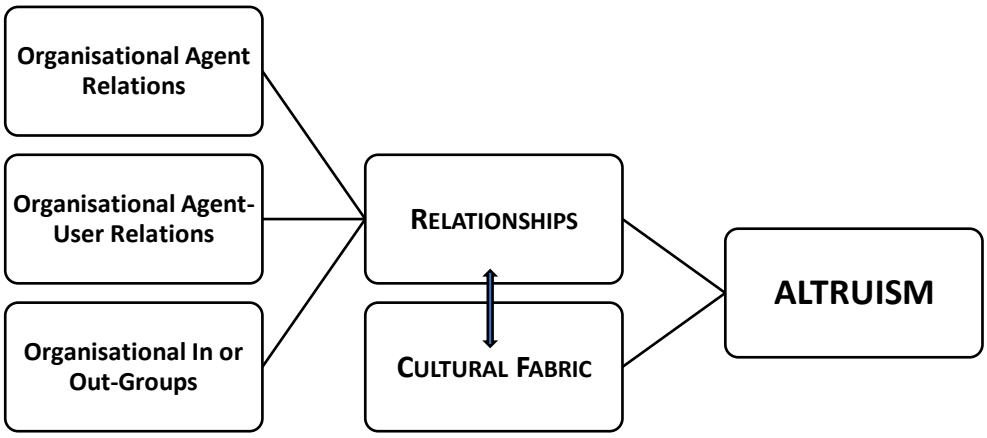
Such factors can affect the visibility or importance of need inside organisational boundaries, the nature of any costs or benefits for addressing it and the resources

available with which to do so. Cultural fabric encompasses norms and sanctions as well as organisational culture and climate. Relationships concern those between agents and users. Organisational architecture includes organisational roles, routines and constraints. Emergent practices which develop inside organisations to promote or inhibit altruism are also considered at the end of this chapter.

3.1 Organisational Relationships and Altruism

Some theories see altruism as part of a system of social exchange within which relationships manage or moderate our helping interactions with those both related and unrelated to us (Ridley, 1996; Fehr and Fischbacher, 2003; Penner et al., 2005; West et al., 2006; Scott and Seglow, 2007; Kurzban et al., 2015). This system of exchange includes people's roles, the groups or networks they belong to, as well as the broader cultural, societal or institutional arrangements within which they are situated. These delineate people's respective positions, carry associated expectations concerning their benevolence or reciprocity towards each other and govern their altruism accordingly. This section sets out the main relationships in an organisational context which may promote or inhibit altruism (see Figure 3).

Figure 3: Organisational Relationships and Altruism



These include relationships between organisational agents, between agents and users and between any associated in or out-groups. It is acknowledged that these relationships will also affect, or be affected by, the culture of the organisation or its staff.

Much prosocial behaviour is driven by relationships within (or between) groups, societies or cultures which enable us to co-operate with both related and unrelated members (Kurzban et al., 2015). Importantly for the organisational context, group members are more willing co-operate or benefit other members, even at their own personal expense (Balliet, Mulder and Van Lange, 2011; Balliet, Wu and De Dreu, 2014). Altruism is shown to corelate strongly with the cohesiveness of a group, or the commitment and concern of its members towards it (Podsakoff et al., 2000; Rioux and Penner, 2001; Lemmon and Wayne, 2015; De Geus et al., 2020). Moreover, studies show that not only are we more likely to help a stranger who is perceived to belong to the same group as us, but the effect is pronounced if we are primed to make our sense of group affiliation more salient (Levine, Prosser, Evans, and Reicher, 2005) or we believe fellow group members are dependent upon us (Slater, Rovira, Southern, Swapp, Zhang, Campbell and Levine, 2013). This means that the way in which organisational contexts frame their members as belonging to, or excluded from, their boundaries should affect altruism. A similar pattern should also be evident within or between discrete internal groupings, an organisation's teams, departments, hierarchical tiers and so on. So, altruism as an organisational construct, may need to develop understanding of how internal contexts or conditions create perceptions of in and out-group boundaries.

There is also considerable evidence for an affective effect within in-groups which promotes altruism: we exhibit strong empathic reactions towards the suffering of group members which, in turn, stimulates helping (Shroeder et al., 1995; Stürmer, Snyder and Omoto, 2005; Mathur, Harada, Lipke and Chiao, 2010; Singer and

Klimecki, 2014).[12] Transposing this into an organisational context, the cognitive and affective connections which promote helping at the individual level could infuse in-group relations, making teams or units more sensitive to each other's needs or distress. Such patterns would affect altruism between members or non-members of cohorts inside the organisation as well as towards those deemed insiders or outsiders of the organisation as a whole. Thus, in healthcare, altruism might be influenced by perceptions of patients as outsiders or by agents' sense of belonging to different staff groupings, for example nurses versus doctors, management versus staff or one speciality versus another.

Some theorists see altruism arising from the need for cooperation within groups or competition between them (Ridley and Dawkins, 1981; Ridley, 1996). According to such theories, just as individuals may act for egoistic as well as altruistic reasons, so might groups. Sober and Wilson (1999), for example, argue that group evolution is feasible, since those with more altruists in them might have an advantage over those comprised of predominantly selfish members. Considering this in an organisational setting raises questions about the extent to which employees (as a body) are prepared to make altruistic sacrifices of their own time, effort, wellbeing and so on, for the good of the organisation. People are prepared to make extraordinary sacrifices for organisations they belong to (Qirko, 2013; Barber, 2004). There is a body of evidence that commitment to, or affective concern for, one's organisation (as a group) promotes altruism towards the organisation (Rioux and Penner, 2001; Chahal and Mehta, 2010; Lemmon and Wayne, 2015; De Geus et al., 2020). Drawing on such group level theories, Clarkson (2014) proposes a model of altruism in which the success of the organisation, as a group, depends upon the altruism of its staff, as in-group members.

[12] Conversely, some of these studies show personal attraction is a much greater predictor of helping for out-group members. A factor which would be relevant in situations where patients are disliked.

Working on the basis that the overall success of the organisation will realise the success of its members, in Clarkson's model altruism becomes the primary employment relationship or means of exchange, with staff acting altruistically for the benefit of the collective. According to this model, an organisation's success depends upon its degree of horizontal collectivism, that is the primacy given to its goals and the equality accorded to members who contribute to its success. Clarkson argues that a collectivist culture, in which organisational members' equality and interdependence is accepted, will promote altruism, encouraging the development of an internal altruistic social norm regardless of any starting norms. Individual staff will act altruistically, influenced by organisational fairness, the autonomy of their roles and their awareness of responsibility, as well as these altruistic norms. For the construct of organisational altruism, this model raises the possibility that it can evolve over time, promoting prosociality within organisational boundaries irrespective of external expectations, reinforced by internal normative feedback.[13] The relevance of the model for healthcare may lie in its explanation of the sacrifices staff are prepared to make to meet internal demands. It could explain, for example, why burnout is so prevalent in the sector.[14]

Moving on from group relations to more discrete ones, there is also a substantial body of evidence that prosocial behaviour is precipitated by our personal or social connections with each other (i.e. family, friends, acquaintances, and so on) (Krebs, 1970; Scott and Seglow, 2007; Kurzban et al., 2015). Our relationships promote prosociality by means of the significance they ascribe to potential recipients, elevating their needs or distress above others and altering our perception of the balance between the costs or rewards for helping (or not helping) them (Schroeder et. al., 1995; Goetz et. al., 2010). Simpson and Willer (2015) argue that our social relationships and networks promote prosociality because of the inherent emotional

[13] This model also indicates the need to consider individual altruism as a possible starting point for horizontal or collective organisation-wide altruism.

[14] Burnout can be seen as an altruistic cost, a costly consequence of the emotional sacrifices which employees make to benefit the welfare of the organisation or its users at the expense of their own welfare.

commitment within them, with those related to each other more likely to be concerned about each other's welfare or assume mutual moral obligations towards its maintenance. They speculate that the visibility which relationships create underpins this process. Interestingly, however, some studies have shown that perceived closeness with connections can have a greater effect on prosocial behaviour than the structural nature of the relationship itself (Curry, Roberts and Dunbar, 2013; Hackman, Munira, Jasmin and Hruschka, 2017). The importance of our emotions for altruism was set out in the previous section (see 2.2.3). Here the emotions generated by relationships, as well as the emotional significance of them, arise as an important feature. This suggests that the quality of relationships inside organisations may moderate or affect the extent to which members help each other.

Exploring this very issue, Lilius and colleagues argue that relational conditions inside organisations can promote the collectivisation or organisation-wide adoption of prosocial activity (Lilius, Worline, Dutton, Kanov and Maitlis, 2011; Lilius et al., 2012). They identify a process whereby high quality connections between members together with dynamic boundary permeable norms promote responsiveness to suffering. According to their model, these motivate organisational members to lessen or alleviate each other's suffering by promoting orientations between them (such as understanding or familiarity) which encourage those who need help to share their pain and those who can provide it to notice their suffering. Thus, the quality of these relationships makes it easier to take the perspective of another and, as a result, increase the prospect of the empathic concern which motivates altruism emerging.[15] Along similar lines, Madden and colleagues argue that increasing both the quality and quantity of social interaction between agents inside organisations increases the chances that they will notice, feel and respond to others' pain or suffering (Madden, Duchon, Madden and Ploughman, 2012). High quality interactions between colleagues certainly does appear to have a positive effect on prosociality (Chahal and

[15] They say that this process starts with everyday practices. For example, acknowledging others or collective decision making, spawned high quality connections, while celebrating others, or addressing conflict fostered helpful norms.

Mehta, 2010). Interestingly, the effect may be a form of cyclical reciprocity. In a study of employee-supervisor relations for example, Deckop, Cirka, and Andersson (2003) found that those helped by their peers are more helpful (in turn). They propose a workplace cycle in which 'repeated reciprocal helping' cumulatively increases staff helpfulness, or, conversely, a vicious circle might emerge from staff withholding aid because they do not receive it (p.107). Importantly, for the construct of organisational altruism, such reciprocity might be normalised by internal contexts, conditions or practices. In an organisation which discourages reciprocity, altruism is likely to spiral downwards.

In healthcare, positive relations with one's peers can promote prosocial action towards them. In their review of the literature on nursing relationships for example, Feather et al., (2018) found that the social character of the workplace environment makes a significant contribution to nurses' prosocial behaviours, including the respectfulness of their social interactions with each other as well as their sense of belonging. Similarly, in another study of nursing Tsang, Chen, Wang and Tai (2012) found that both formal working relationships and informal social connections such as friendship, increase prosocial behaviour inside healthcare organisations. There is even some suggestion that informal supportive relationships exercise a more pronounced effect than formal scrutiny. For example, in their study comparing the impact of peer observation versus peer support, Brock, Lange and Leonard (2016) found that the latter feature, support from one's colleagues, had a much greater and longer lasting effect on the quality of care.

Problematically, however, healthcare is characterised by the kind of poor quality relationships which according to Lilius and colleagues' model would undermine altruism between staff (Lilius et al., 2011; Lilius et al., 2012). Commonly disruptive behaviours include psychological violence, such as intimidation or abuse, and more generalised incivilities, such as anger and disrespect towards colleagues (Oliveira, Silva, Guedes, Oliveira, Sánchez, Torres, 2016). Relationships in the NHS can be extremely fractious. Bullying and incivility is widespread, experienced by large

numbers of staff and likely to be directed at those who challenge bad care (Randle, 2011; Carter, Thompson, Crampton, Morrow, Burford, Gray and Illing, 2013; Hands, 2013). Poor, tense or dysfunctional working relationships have been identified in a number of healthcare scandals or failures, both before and after the case being studied in this thesis (Kennedy, 2001; Walshe and Offen, 2001; Walshe and Higgens, 2002; Walshe, 2003; Kirkup, 2015). Misalignment between sharp-end (frontline) and blunt-end staff is typical, characterised by a tendency towards blame (Dixon-Woods, Baker, Charles, Dawson, Jerzembek, Martin, McCarthy, McKee, Minion, Ozieranski, Willars, Wilkie and West, 2014). Importantly, blaming others correlates positively with bullying them and bullying them correlates negatively with altruism (Thornberg and Wänström, 2017).

Poor relations or tensions between staff also exercise a deeply negative effect on employees' emotional capacity (Wade, Cooley and Savicki, 1986; Lee and Akhtar, 2011; Scott and Duffey, 2015). Critically, a study by Burnes and Pope (2007) showed that NHS environments have a significant negative impact on organisational agents' emotions and are likely to make staff feel isolated, insecure and fearful, as well as powerless, worthless and vulnerable. Their study, in which more than 50 percent of staff had experienced or witnessed bullying and incivility, showed that such conditions induce these negative emotions irrespective of whether organisational agents experience incivility, bullying and so on themselves, or simply witness it happening to others. Taken altogether, it appears that healthcare is a context which often lacks the high quality relationships that are needed to promote altruism, is characterised by a tendency to incivility, hostility, bullying or blame, and has a negative relational climate which is likely to inhibit altruism.

Moving on from organisational agents, relationships with users are also important for altruism as an organisational construct. Grant (2007) proposes a model which can explain altruism towards users, in which prosocial behaviour derives from the relational architecture of jobs which govern interaction between staff and beneficiaries, their interpersonal connections and so on. In this model, relational

architecture increases employees' motivation to act prosocially by connecting them to the impact they have on beneficiaries through their work.[16] The process is such that their job's impact on beneficiaries, together with the nature of their contact or interaction with them, will influence the motivation to behave prosocially.[17] Alongside this, employees' affective commitment, which also derives from their contact with beneficiaries, will have a similar effect. Importantly, according to such a model, jobs vary in the meaningful contact they enable and it is this which then drives prosocial motivation. According to this theory, healthcare would be categorised as having a rich relational architecture, since it provides employees with many opportunities to have a significant impact on patients' lives, as well as meaningful contact with them, by means of the close emotional or physical interactions which arise from caring and treating users. So, the relational architecture of healthcare should create conditions conducive to altruism.

However, one has to ask how the model aligns with the many failures in healthcare where patients are treated without dignity or respect. What is countermanding this relational richness? By way of answer, Grant allows a moderating role for social information about beneficiaries, arguing that organisational and occupational ideologies may define them as either important and valuable, or conversely, stigmatise, devalue and degrade them. For altruism as an organisational construct, one important issue will be how agents (as a group) perceive users (as a group), since positive assessments should promote altruism and negative ones should inhibit it. However, the perception of users in hospital settings is problematic. To begin with users themselves may be seen as difficult or demanding. In a study of patients in primary care for example, Wills and Hahn (1991) found that between ten and twenty percent of patients are considered difficult, a rating associated not with their medical condition or personal demographics, but rather with their nature. Importantly, difficult or demanding clients or customers precipitate extremely negative emotions

[17] Job impact on beneficiaries includes the magnitude, scope, frequency and presentational focus of the work, while contact with beneficiaries includes its frequency, duration, proximity, depth and breadth.

which are shown to promote uncivil responses in turn (Koopmann, Wang, Liu and Song, 2015).[18] So, a pattern of incivility between doctors and patients could be cyclical. Importantly, the thoughts or feelings which users stimulate amongst staff may be difficult to manage.

The previous chapter indicated that perceiving the distress of another is not enough to promote altruism (see 2.2.3). The nature, direction and intensity of the emotions that this provokes is pertinent. These can inhibit altruism by means of their effect on arousal levels. Healthcare is characterised by complex states of ill-being, which can disrupt relationships between agents and users and evoke difficult emotional states amongst them, such as shame, guilt, fear or anger and even victimhood (Ballatt and Campling, 2011). Critically, it is a context which can provoke excessive emotional reactions amongst staff which they may direct towards patients (such as anger or disgust) or themselves (such as guilt or shame). These may include emotions such as dislike or disgust, which would be out of kilter with normative expectations of their profession. An issue for altruism as an organisational construct is the effect of sectors which are structured to include a large population of distressed and demanding users, who stimulate deeply uncomfortable emotions amongst those there to help them. Considering that issue in healthcare, the agent-user relationship is a site of 'unacceptable' emotions which discomfit employees and patients alike. This is likely to undermine the relational architecture Grant outlines.

One way to explain why Grant's rich relational architecture does not always produce altruistic or prosocial behaviour in healthcare, is a normalised devaluation of patients' pain or suffering in response to this discomfiting situation. A number of healthcare failures have been characterised by the diminishment or dehumanisation of users (Flynn, 2012; Neuberger, 2016; Darbyshire and Ion, 2019; Gosport Independent Panel, 2018; Hilton, 2019; Richards, 2019). Relevantly, according to Grant's model, within organisations social information may characterise either

[18] They argue it may also precipitate a sense of failure as a result.

patients as less worthy (for example, there is something underserving about them as people) or as having a less legitimate claim upon employees for assistance (for example, they are not as ill as they say they are). The perceived legitimacy of recipients, and any appropriate or accepted dependencies, promotes altruism, while illegitimately perceived expectations have a deleterious effect (Berkowitz and Daniels, 1963; Krebs, 1970; Shroeder et al, 1995). It matters whether we think others deserve their suffering, because our feelings expose us to exploitation by unworthy beneficiaries if we err in such assessments (Goetz et. al, 2010). However, even if patient suffering is genuine, healthcare professionals may diminish that by reframing patient suffering as deserved, or absolve themselves of responding by saying that the condition is not serious, that the patient deserves it (i.e. they brought it on themselves) or that they are personally undeserving (i.e. unlikeable, unpleasant) (Faust, 2009). Diminishment strategies such as these may be an important element for altruism as an organisational construct.

This is because diminishing others' suffering is a way to psychologically avoid seeing their welfare needs as deserving of aid, since it can erode both the legitimacy of the recipient who needs aid and the validity of their dependency upon you for providing it. Such a process is evident in organisations or institutions which dehumanise members (Stanton, 1998; Zimbardo, 2004; Zimbardo, 2007; Reimann and Zimbardo, 2011). A common feature of such situations is the combined lessening of the suffering of one group, together with a reduction in the responsibility of another group for responding. Thus, other-orientation is eroded by a particular framing of potential givers and recipients in relation to each other. This framing appears to be the exact opposite of what the literature regarding individual beliefs indicates is needed for altruism (see 2.2.2). So, if organisations generate or institutionalise social information about agents or users in this way it would be likely to inhibit altruism. An issue for healthcare organisations, in particular, may be their potential to generate diminishing presentations of users. Where user distress is thus denuded of its significance, then the cues that help is needed can be ignored or neglected.

An alternative explanation for why the rich relational architecture of healthcare envisaged by Grant's model does not normalise altruistic or helping behaviour may be imbalances in agent-user reciprocity. According to the theory of reciprocal altruism, we act altruistically in the short-term to secure benefits in return longer-term (Trivers, 1971).[19] The concept of reciprocal altruism (or strong reciprocity) has been substantially proven to stimulate altruistic action or prosocial behaviour (Gintis, 2000; Fehr et al., 2002; Gintis, Bowles, Boyd and Fehr, 2003; Nowak, Vallacher and Miller, 2003**;** Feyr and Rockenbach, 2004; Nowak and Sigmund, 2005; Nowak, 2006). Reciprocity helps us manage the tensions between our own self-interest and our groups' collective interest (Van Lange, Joireman, Parks and Van Dijk, 2013). Transposing this concept into healthcare settings exposes a problem in the staff-patient relationship. There is an inherent and potentially damaging structural tension between the interests of patients and users, which is not always acknowledged. Healthcare professional contact with patients, and the strain that it can cause, is a structural source of stressful interaction.

From a five-year longitudinal study of UK general practitioners for example, Bakker and colleagues found that contact with demanding patients undermines the reciprocity of the doctor-patient relationship, draining doctors of emotion, depleting them of physical resources and undermining their sense of efficacy (Bakker, Schaufeli, Sixma, Bosveld and Van Dierendonck, 2000). Importantly, they identified a pattern whereby practitioners take steps to distance themselves from patients, fostering more demanding behaviour from users in turn.[20] Pertinently, they argue that the structure of the relationship itself is out of kilter since it positions practitioners as solely giving and patients as solely receiving, with the costs for doctors, their time, energy, effort and so on, inadequately balanced by the rewards that patients can confer upon them, such as gratitude. That is, the structurally

[19]Reciprocal altruism is also regulated by social emotions such as sympathy or gratitude (Trivers, 1971).

[20] In their study, if doctors reported a negative attitude towards their patients at the first point measured, this predicted patients' demandingness at the second point measured, leading them to conclude that the detachment professionals need to carry out their roles can – if too detached or cynical – can actually undermine the relationship.

unbalanced nature of the contact between the two groups generates a perceived lack of reciprocity in the relationship which not only depletes employees' emotions but eventually fosters cynicism or callousness towards patients. Importantly, gratitude regulates how we respond to altruism, by propelling us to acknowledge the benefits that we have received and stimulating us to return benefits 'in kind' to those we have received them from (Emmons and Shelton, 2002; McCullough, Kimeldorf and Cohen, 2008). Although one could argue that healthcare professionals should not expect gratitude given their duty of care, should they see patients as ungrateful it could undermine altruism. Put more simply, who would want to go the extra mile for someone who appears ungrateful and who would not want to go the extra mile for someone that does.

So, there are two alternative explanations for why the rich relational architecture of health might fail to deliver altruism. One is normalised patient diminishment. The other is unbalanced reciprocity. Both raise the possibility of users being treated as an unworthy or ungrateful out-group. According to Ballatt and Campling (2011) healthcare services already operate at the edges of kinship, where there is a tension between goodwill towards, or rejection of, certain groups of patients deemed less worthy by society more generally.[21] Critically, out-group members can be treated differently. We can perceive them with reduced warmth or disgust (Harris and Fiske, 2006), rate their pain far less negatively (Hein, Silani, Preuschoff, Batson and Singer, 2010) or be deterred from altruism towards them by out-group prejudice (Bednall and Bove, 2011). Decreasing others' value, lessening or even blaming them, makes cruelty or callousness permissible (Staub, 1985; Staub, 2004). In healthcare, if staff (as one group) see patients (as another group) as lesser, either unworthy or ungrateful, it gives them permission to collectively treat, or feel about them, differently. Should such a stance become normalised, altruism towards patients would be severely diminished. However, so would good care.

[21] By way of an example an injured drunk might stimulate feelings of kindness concerning their injuries but their drunken state might prompt ambivalence, or generate a reluctance to treat them or even provoke hostility.

Clarkson's model (2014) can explain why employee populations might make altruistic sacrifices, such as time, effort and so on, to meet demanding organisational goals or targets. Grant's model (2007) can explain how information might be used against certain groupings within the broader organisational entity, with one group pitted against another. Neither quite account for why the complete breakdown between organisational agents and users is so prevalent in healthcare contexts. But together they might do so by indicating what would happen if the success of the organisation, as a group, was seen to be misaligned with the demands of its users. Should such a situation arise, diminishing patients could help reconcile any tension staff experience between acting in the perceived interest of the organisation as a whole and responding to the welfare needs of individual users in day-to-day practice. In the NHS that might be a choice between spending your time on meeting a target which would benefit your organisation in national rankings, as well as meet approval from your manager, or spending it on tending to a request from a patient which might interrupt your doing so.

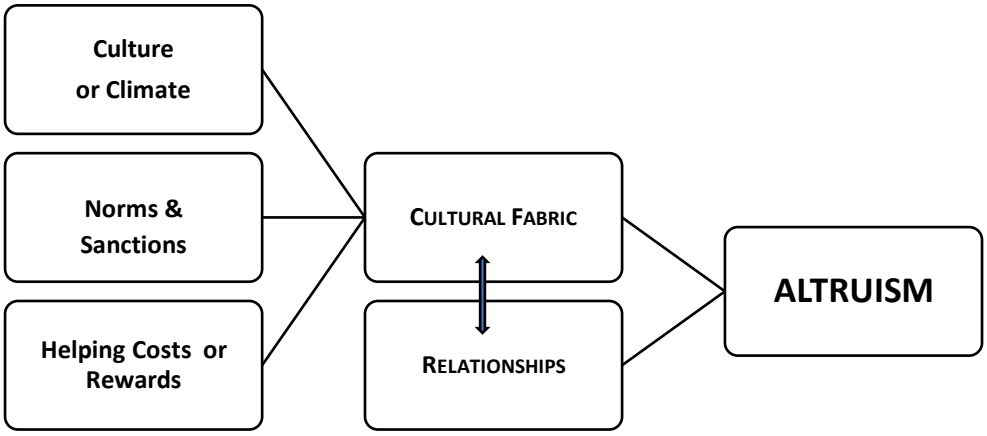
3.2 Organisational Cultural Fabric and Altruism

Cultural theories of altruism tend to see it as emerging or evolving in line with broader environmental factors. Theorists argue that we develop or acquire group level traits for altruism in line with our cultures, environments and the cooperative needs or requirements inherent in them (Gintis, 2000; Gintis et al., 2003; Fehr and Fischbacher, 2003; Bowles, Choi and Hopfensitz, 2003; West et al., 2006; Wilson and Wilson, 2007; Wilson, 2015). Though comparative analysis is rare, cross-cultural studies have shown that differences at this level account for much variation in altruism, and even imply that our preference for prosocial behaviour may evolve over time as a result of our social or cultural environments (Henrich, Boyd, Bowles, Camerer, Fehr, Gintis, McElreath, Alvard, Barr, Ensminger, Henrich, Hill, Gil-White, Gurven, Marlowe, Patton and Treacer, 2005). Transposing this into an organisational setting, one would expect that as societal cultures evolve over time to value altruism, institutions or organisations within them will be shaped and reshaped accordingly.

However, organisations themselves might also exhibit evolving capacity for altruism in alignment with their own particular industry, service, country or occupational environment. [22]

This section will set out the main elements of an organisation's cultural fabric which may play an evolving role in promoting or inhibiting altruism within their boundaries (see Figure 4).

Figure 4: Organisational Cultural Fabric and Altruism



Culture is likely to work in conjunction with member relationships, especially in respect of its influence on the internal value placed on users discussed in the previous section. Costs and rewards are likely to be generated both by an organisation's culture as well as the arrangement of its activities, hierarchies and services. For that reason, a consideration of costs and rewards is demitted to the next section (see 3.3).

[22] Such an approach is intimated by Clarkson's (2014) model discussed earlier (see 3.1).

Social structures, cultures and institutions govern expectations of interaction between those located within their sphere. Prosocial behaviour is founded in expectations that are influenced by what we think others will do, as well as what we think they think that we will do (Pereda, Branas-Garza, Rodriguez-Lara and Sanchez, 2017). Institutions provide shared social prescriptions governing our thoughts and behaviours (Dequech, 2009; Herepath and Kitchener, 2016). Social environments come with associated norms concerning how members should relate to each other. Importantly, within groups, these 'systematize, standardize, and contextualize …which prosocial (or antisocial) behaviours are expected, when, and toward whom' (Jensen et al., 2014, p.11). Both descriptive and prescriptive norms provide prosocial motivation (Bednall and Bove, 2011).

Those norms which promote altruism in particular include: the norm of social responsibility, which stipulates that people should help those who are dependent on them (Berkowitz and Daniels, 1963); the norm of reciprocity, which stipulates that people must help, but not harm, those who help them (Gouldner, 1960); and the norm of conditional cooperation, which stipulates that you cooperate if others do, but defect if they do not (Fehr and Fischbacher, 2004). While all these might be relevant to altruism between agents within organisations, the first, that of dependency, should be particularly relevant for prosocial behaviour towards patients in healthcare settings. Problematically, however, the discussion on user diminishment in the previous section (3.1) shows how this might be subverted. Picking up on Jenson's point about norms establishing to whom prosocial action is appropriate, reframing patients can obviate the applicability of such a norm to them as a group (Jenson et al., 2014).

Organisational cultures in which prosocial behaviours are maximised for the benefit of the organisation as a whole are characterised by the adoption of a higher purpose, encouragement of employees to pursue overall group benefit rather than individual employee rewards and promotion of group identities or collaboration practices (Vieweg, 2018). Although the relationship that internal values have with altruistic

behaviours inside of organisations has not been well studied, the literature suggests that those which promote self-transcendence over self-enhancement are likely to play a role (Arieli et al., 2020). Organisations characterised by collectivist or team based cultures, for example, are shown to encourage more prosocial behaviour (Lievens, Conway and De Corte, 2008; Limpanitgul, Jirotmontree, Robson and Boonchoo, 2013). In their detailed study of helping in different cultures, Perlow and Weeks (2002) found that employee helpfulness is substantially influenced by the culture of their occupation, organisation and nation (Perlow and Weeks, 2002). Pertinently, however, they found that internal organisational culture had a potentially much greater effect than external societal culture, and could stimulate either 'a generalized expectation' of helping or a form of 'restricted reciprocity', in which staff are more likely to help those from whom they expect they will want help in return. Thus, it appears that organisational culture, as well as any integral norms and values, can promote altruistic behaviour, albeit to differing degrees.

In considering altruism as an organisational construct, one also must take account of the potential interaction between members' own personal norms or values and their organisation's cultural norms and values. In their study of virtuousness within organisations for example, Bright and colleagues found that some members adapt pragmatically to internal contexts (and the norms within them) while others can transcend such situations with more virtuous behaviours (Bright, Alzola, Stansbury and Stavros, 2011). Similarly, in their study tracking the conduct of managers and employees over five years, Paarlberg and Perry (2007) found that the influence of organisational values upon staff motivation depended on the extent to which they aligned with employees' own views, values and perspectives on reciprocity. So there is a duality to the influence of cultural norms, values and beliefs, which altruism as an organisational construct must concede.

A number of the theoretical models seeking to explain altruistic or prosocial behaviour allow a role for organisational culture and associated norms or values (Kanov, Maitlis, Worline, Dutton, Frost, Jacoba and Lilius, 2004; Dutton, Worline,

Frost and Lilius, 2006; Treviño et al., 2007; Kish-Gephart, Harrison and Treviño, 2010; Lilius et al., 2011; Lilius et al., 2012; Clarkson, 2014; Dutton et al., 2014). Dutton and colleagues argue that values regarding the 'holistic personhood' of others and the permissibility of expressions of humanity within an organisation are more likely to increase the likelihood that members' pain is collectively noticed, felt and responded to (Dutton et al., 2006). Similarly, Kanov et al., (2004) argue that organisations with humane cultures which value expressions of suffering, and encourage members to share their feelings, accordingly, will generate more action to address others' needs or welfare, legitimising action fuelled by feelings for others.

In their exposition of relational responding, Lilius and colleagues also acknowledge a role for internal organisational norms which influence the boundaries between work and personal life and indicate that it is appropriate and important to put one's humanity on display. This, they say, makes it permissible to openly share one's pain or distress which, in turn, is likely to stimulate empathic concern (Lilius et. al., 2011; Lilius et al., 2012). Critically, what these models do is show that organisational culture might generate shared internal concepts of common humanity (see Monroe, 1996), validating and disseminating them internally in ways which would encourage altruism between members. However, the valuable organisational element they add to Monroe's theory is the importance of your 'being' human, that is modelling or sharing your common humanity, so others will follow, as well as 'seeing' common humanity in others.

In healthcare, culture is shown to have a significant effect on patient safety and care (Pronovost, Berenholtz, Goeschel, Needham, Sexton, Thompson, Lubomski, Marsteller, Makary and Hunt, 2006; Kaplan, Brady, Dritz, Hooper, Linam, Froehle and Margolis, 2010; Reader and Gillespie, 2013; Jacobs, Mannion, Davies, Harrison, Konteh and Walshe, 2013). Those cultures which appear particularly pertinent for care include cultures of compassion, in which users are humanely treated, cultures of blame which constrain transparency about harm to patients and cultures of bullying or unrelenting pressure to meet targets which generate unintended and

dysfunctional consequences (Herepath, Kitchener and Waring, 2015). Worryingly, however, in a study of prosocial behaviour amongst UK healthcare employees, few identified organisational culture as a common reason for acting prosocially, given by only 12 percent of those studied (Hyde et al., 2013). Even more problematically, in the NHS a large number of failures have been attributed to cultural deficiencies, such as club cultures, old boy's cultures or cultures of secrecy and suppression, which enable patient mistreatment (Kennedy, 2001; Walshe and Higgens, 2002; Walshe 2003, Walshe and Shortell, 2004; Walshe, 2003; Walshe, 2014; Kirkup, 2015; Gosport Independent Panel, 2018). Such cultures may be characterised as either exhibiting affective lapses, those in which users have been treated uncompassionately, or moral lapses, in which they have been treated unethically, or both.

Considering the first type of lapse, in many of these cases, the organisations (and their staff) have been seriously criticised for cultures lacking in kindness, compassion or concern for the welfare of patients (Ballatt and Campling, 2011; Department of Health, 2012; Neuberger, 2013). Although we desire professionals to be empathic and compassionate, this appears to be rare in medical settings (Camel and Glick, 1996; Firth-Cozens and Cornwell, 2009). In healthcare, depleted affective capacity, emotional exhaustion and compassion fatigue are both widespread and well evidenced in their negative impact on professional capacity and patient care (Leiter and Maslach 1988; Maslach, Schaufeli and Leiter, 2001; Cameron, Mazer, Deluca, Mohile and Epstein, 2015; Van Mol, Kompanje, Benoit, Bakker and Nijkamp, 2015; Cocker and Joss, 2016; Sorenson, Bolick, Wright and Hamilton, 2016; Papadopoulos and Ali, 2016; Sorenson, Bolick, Wright and Hamilton, 2017; Maslach and Leiter, 2017). Worryingly, compassion fatigue can reach 'zombie phase' in which professionals completely lose sight of the needs of those they are there to help (Grant et al., 2019, p.2).

The literature concerning individuals indicates that developing other-orientated feelings stimulates altruism, but that one's level of affective resource can moderate any effect. Here, it appears that healthcare organisations are beset with employee

populations whose levels of affective resource are lowered. Critically, the emotional demands of working in human services industries exhaust employee capacity to engage with, or respond to, users' needs, and those involved seek to manage the emotional strains of such work by distancing themselves from it, which can result in their becoming excessively detached from clients, dehumanising them or even treating them callously (Maslach, Schaufeli and Leitner, 2001). Exploring this problem in UK healthcare, Crawford and colleagues identify the erosion of compassion mentalities (Crawford, Gilbert, Gilbert, Gale and Harvey, 2013). They ascertained the presence of such a mentality in professionals' reduced use of compassionate language, increased use of production line terminology, linguistic attempts to put emotional distance between them and their patients and adoption of a lexicon which indicates that their focus is on processing patients to meet organisational goals. All this suggests that the argument put forward by Ballatt and Campling (2011) that the culture of the modern health service is poorly suited to managing the emotional labour involved is correct. As shown in the discussion of individual affective traits, other-suffering emotions promote altruism. In a context where these are collectively muted, altruism is far less likely. So, an important question for altruism as an organisational construct, therefore, is how organisations can maintain a high level of collective affective resource, in particular those emotions, such as compassion, which promote altruism.

Another theory put forward by Crawford and colleagues, which might explain the absence of concern for others' suffering within healthcare is the presence of threat cultures (Crawford, Brown, Kvangarsnes and Gilbert, 2014). These are characterised by: 'discourses of insecurity'; significant pace or pressure, evident in employees' perception of 'working to the clock' or 'under the eye of the clock'; their having to do so with strained resources or limited staffing capacity; and their having to handle the negative consequences of failing to meet organisational targets; as well as intensive approaches within clinical domains (Crawford et al., 2014, p.3592). Crawford and colleagues argue that such cultures actually create mental states which push employees to focus on their own self-defence and eschew other-

orientated emotional stances inside organisations. So, reduced affective capacity or emotional resource may be attributable to contexts which are insecure or unstable and heighten their agents' sense of vulnerability. Drawing on this model, one can speculate that collectively self-orientated, other-avoiding agent populations are the most significant early warning sign for affective lapse in healthcare settings. Though no systematic study of threat culture in the sector appears to have been undertaken as yet, evident cultures of blame and bullying discussed earlier appear to support their theory.

Though it may play a very important role for altruism as an organisational construct, reduced affective capacity is unlikely to explain an absence of prosocial activity inside organisations on its own. Another explanation may be found in ethical breaches. Moral responsibility is an inextricable part of the healthcare sector's identity (Pijnenburg and Gordijn, 2005). Problematically, in the UK a number of healthcare scandals or failures have been characterised by the unethical treatment of patients (Redfern, 2001; Dewar and Boddington, 2004; Knights, Wood and Barclay, 2013, Kirkup, 2015; Gallagher and Gannon, 2018). The organisational ethics underpinning healthcare can be framed as the need to provide care with compassion, an approach in which the healthcare organisation's role is that of caregiver, its stakeholders are patients and its values are those of trust and compassion, but it might also be framed as acting in the public spirit, an approach in which its role is that of helping citizens, its stakeholders are the community and its values are those of community benefit and the common good (Winkler, Gruen and Sussman, 2005). Breaches of the former compassionate caregiving role may be seen as affective lapses, caused by reduced affective resources. Breaches of the latter public spirited treatment of patients as citizens may be considered as ethical lapses, potentially caused by a contraction of the organisation's moral sphere to exclude outsiders.

The previous chapter on individuals showed how their morally founded views about others may (or may not) promote altruism. Our beliefs can be neutral. So, organisational cultures might play a role in promoting or inhibiting altruistic

behaviour towards members by stimulating positive or negative moral evaluations. Organisation's climates can incentivise ethical or unethical behaviour (Treviño at al., 2006). The perception of organisational cultures as fair or just has a significant impact on altruism (Chahal and Mehta, 2010). By way of a highly illustrative example, in a correlational study of ten businesses (five family owned firms and five non-family firms), Ceja, Escartín and Rodríguez-Carballeira (2012) found that the perception of internal organisational contexts as balanced or positive correlated with high levels of altruism and low levels of mobbing (negative acts such as withholding information), whilst perceptions of them as unbalanced or negative led to the exact opposite, low altruism and high mobbing. However, studies have also shown that while perceiving organisational climates as just stimulates prosocial behaviour amongst employees who are already highly orientated towards others, the effect is much reduced amongst those with less well developed other-related stances (De Dreu and Nauta, 2009). So, an ethical climate may still be somewhat dependent for its influence upon the moral stances of employees.

In their model of ethical behaviour inside organisations, Kish-Gephart and colleagues argue that whilst employees' moral development will influence their ethical or unethical intentions or behaviour towards others, the process will be influenced by whether the culture is ethical and the climate is benevolent or principled (Kish-Gephart et al., 2010). According to this model, benevolent climates are those in which employees are altruistically concerned with the welfare of others. They found substantial evidence in the literature that organisations can function as 'bad barrels' with social environments that promote unethical choices within their boundaries. In particular, those with cultures that promote everyone for themselves encourage unethical actions towards others, whereas those which benevolently direct their employees' attention to staff and customer wellbeing, or principledly direct them to follow rules which safeguard the organisation and its members, will promote ethical action. Although the model is not designed to explain altruism, the way it takes account of the moral tenor of organisational cultures in the mistreatment of members may help to explain ethical lapses within healthcare.

Affective explanations of healthcare failure indicate how prosocial behaviour may be undermined by a lack of positively directed other-orientated emotions within organisations**.** Moral or ethical models suggest how prosocial behaviour might be undermined by an absence of positively directed other-orientated values or beliefs inside an organisation. However Kish-Gephart's model allows for both influences. This is very much in keeping with Canter et al.'s (2017) argument that affective motivations for altruism also require ethical toleration of, or principled stances towards, others if they are to be effectual, and vice versa. Both are required. Drawing on Kish-Gephart's model, one can speculate that cultures which are characterised by a combined absence of principled or benevolent stances might explain healthcare organisations' well-evidenced mistreatment of users in particular. For altruism as an organisational construct, it suggests that both the moral and emotional tenor of organisational cultures may be relevant.

A couple of models more discretely explore the role of normative elements within organisational cultures on altruism. As already noted Clarkson (2014) gives normative influences considerable prominence, envisaging an interaction between individual and collectivist altruistic norms. Li, Kirkman and Porter (2014) develop a team based model of altruism, which pertinently depicts normative influences that might affect the development of altruistic team-level motives over time. In their workplace model, team-altruism is defined as:

> 'team members' interdependent, voluntary actions benefiting others (e.g., fellow team members, their own team as a whole, those outside the team) that involve self- sacrifice and are not mandated by central authorities (e.g., team leaders, managers) or formal sanctions.' (p.541).

By way of an example, they identify teams collectively sharing the work of a colleague who is ill. Within this model, altruism is prosocially motivated to enable team members to get along. In the initial stage, team members individual altruistic actions foster coordination processes which promote such behaviour at a team level between in-group members. The process is then normatively sustained, encouraging

followers to behave altruistically as well in order to meet their colleague's expectations.[23] Thus, although altruism may be initiated by just a few team members, norms arise in which it becomes more generally expected or accepted, and a motivational shift occurs in line with that, in which team members adapt to meet (and fit in with) expectational circumstances for reputational purposes. Although these models helpfully provide a normative foundation for altruism, they are perhaps somewhat limited in their applicability to the complexities of healthcare environments.

A more useful exploration of how relevant cultural or normative influences might work together in this sector may be found in the research of Scott on institutions. Scott (2003) defines institutions as 'a system composed of regulative, normative and cultural-cognitive elements that act to produce meaning, stability and order' (p.879). According to his thesis, institutional order is underpinned by: regulative factors which influence behaviour by means of rule-setting, monitoring mechanisms and sanctioning systems; normative factors which establish social expectations, prescriptions and obligations and cultural-cognitive elements which create shared meaning (Scott, 2003). Importantly, for a study of altruism, institutions establish patterns of social interaction which could involve behavioural expectations of prosociality or reciprocity between organisational agents or between agents and users, as well as towards the organisation as a whole.

Within Scott's regulative dimension one might speculate that people help as a matter of expediency, doing so because of rules that require it, their legitimacy coming from formal sanctions associated with inaction. Helping in such circumstances would not be considered altruistic, since potential givers' actions are a matter of egoistic compliance.[24] Importantly, however such rules could make

[23] Somewhat along the same lines as Kish-Gephart, this model allows for moral principles as well as positive emotional orientations towards others, though the latter construct is conceptualised as empathy rather than benevolence. However, it does not explore their interaction deeply.

[24] Despite this are Civil assistance laws may oblige bystanders to provide first aid or assist someone in danger (e.g. in Germany and France). More pertinently, Good Samaritan laws (e.g. Canada) can protect bystanders who seek to

altruism more or less costly. For example, a 'Duty to Speak Up' in healthcare would make whistleblowing less costly. Moving on to his normative dimension, people might help others as a matter of social obligation, with the legitimacy arising from moral stances about helping, such as those discussed in the section on individual beliefs (see. 2.2.2). In such circumstances, helping could be egoistic, altruistic or both. Lastly, within the cultural cognitive dimension, helping others may (or may not) be a taken for granted action, prompted by certain schema, with legitimacy arising from broader cultural conceptualisations about helping others.

One can draw on Scott's modelling of institutional theory in healthcare to theorise about the nature of institutional influences on altruistic helping (Ruef and Scott, 1998; Scott, 2008). The effects he predicts might be seen in a consideration of the elderly. Hospital routines, for example, could have protocols or standards related to the increased dependencies of the elderly, covering aspects such as falls or dementia. These might be legitimised by hospital rules, professional bodies or national regulators. Following these could not be deemed altruistic. However, alongside those routines there may be normative drivers. Certain roles, such as nursing, may be infused with expectations about compassion, which morally or socially oblige postholders to behave towards patients in a certain way. In addition, there may be broader cultural aspects which enhance this. There could be certain scripts about how the elderly should be treated, for example with respect or deference. Thus, a healthcare assistant might undertake more small acts of personal kindness towards senior citizens on the ward than other patients because of their age. What is lacking in such an assessment is the feelings which staff may have about the elderly. Alongside certain shared schema about this group which stipulates respectful or courteous treatment will be employees' affective responses. Sympathy for an older person's genuine frailty could promote altruism. However less positive social emotions, such as disgust precipitated by their physical symptoms could

help victims from being sued for wrongdoing.

inhibit it. Scott's model does not necessarily align easily with affective explanations of altruism.

Despite this, explanations of why altruistic or prosocial behaviour is inhibited in healthcare may be found in conflicts between Scott's pillars. In healthcare, there is a definite clash between the institutional espousing of humanistic norms of altruism and compassion and some of the more implicit customs or cultural practices evident in medicine (Burks and Kobus, 2012). Crawford and colleague's model of threat culture (2014), for example, implies that the NHS is a site of conflict between the regulatory pillar, in the form of institutionalised targets, and the cultural pillar, in the form of shared beliefs about treating patients compassionately. Just such a dialogue is evident in their studies of health care practitioner language which reveal moral or normative imperatives to act in particular ways alongside rules-based recognition or acceptance that one might not necessarily be free to do so (Crawford et al., 2013). Employees' language indicated tensions between their professional norms about patient care and the organisation's formal expectations of performance. Helpfully, Scott (2003) recognises that different pillars may predominate in different settings. What this indicates for altruism as an organisational construct is the need to allow for different cultural or institutional elements directing staff in directly contradictory ways that might compromise helping.

Arguably, these tensions expose organisational members to significant conflict. Firstly, internal psychological conflict might arise as staff seek to balance the different imperatives or constraints created by these different pillars within their workplace environment. That might promote negative affective states, such as feeling guilty, or negative cognitive states, such as feeling inefficacious. The former might constitute a form of self-sanctioning.[25] Importantly for altruism as an

[25] There is a substantial body of evidence in that positive or negative sanctioning (or norm enforcement) is one of the main methods used to compel prosocial behaviour from others within groups and institutions (Fehr and Fischbacher, 2003; Fehr and Gächter, 2002; Fehr, Fischbacher and Gächter, 2002; Fehr and Fischbacher, 2004). Negative sanctions might include informal actions, such excluding or ostracising employees, as well as the exercise of more formal penalties. Positive sanctions might include informal actions such as casual praise or tacit approval,

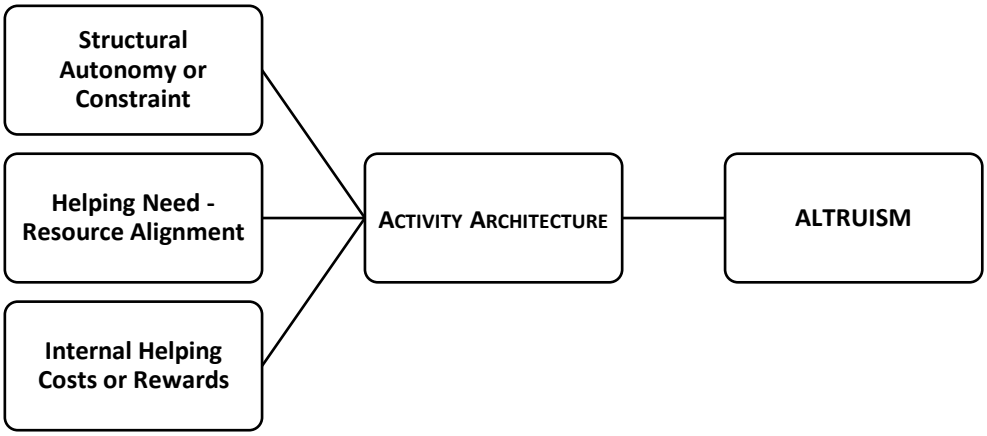
organisational construct there are significant self-imposed sanctions associated with not helping others. Staff may, for example, experience shame, blame themselves or feel responsible for inaction (Shroeder et al, 1995). The discussion of such personal traits at the individual level (see 2.2.1, 2.2.2 and 2.2.3) has already illustrated the inhibitory influence of such traits for altruism. A second source of internal conflict might be that between legitimating authorities seeking to uphold elements within different pillars. This would create a negative relational environment. The negative impact of relational conflict on prosociality was established earlier in this chapter (see 3.1). In healthcare, the fight between professional and managerial legitimacy identified by Scott is likely to be a significant source of such conflict (Scott, 1998; Scott; 2008). It may generate intense other-sanctioning inside organisations as different authorities seek to enforce compliance. Intense sanctioning could create an environment in which prosocial action is much more costly. As we shall see in the next chapter, where the costs for helping imposed by an organisation are high, altruism is likely to be inhibited.

3.3 Organisational Architecture and Altruism

As physical entities, organisations are constituted by means of interlocking structures and systems through which their activities are led, managed, resourced and delivered. For the purpose of this study, such features are called an organisation's activity architecture. As this section will show, altruistic or helping behaviour is influenced by the autonomy allowed to (or the constraint exercised over) organisational members by this architecture, as well as the resources available within it and any costs or rewards for helping members that it creates (see Figure 5 on the next page).

as well as official rewards, awards, titles and so on

Figure 5: Activity Architecture and Altruism



Starting with organisational governance, leaders wield significant influence over prosocial behaviour. Support from leaders, their rules, or our power to influence them, govern how we manage tensions between our personal interests and the broader group's collective interests (Van Lange et al., 2013)**.** In theory, leaders might promote prosocial behaviour by modelling it as acceptable or desirable, by supporting, rewarding or penalising employees who undertake such actions or by means of the constraints and restrictions they impose on staff. Leadership itself has a significant and consistently positive relationship with prosocial behaviour inside organisations (Organ and Ryan, 1995; Podsakoff et al., 2000; Asgari, Silong, Ahmad and Samah, 2008; Chahal and Mehta, 2010; Podsakoff et al., 2014; De Geus et al., 2020). Styles of leadership associated with altruism include: authentic leadership, which demonstrates or encourages prosocial behaviour by means of moral or ethical factors such as transparency; spiritual leadership, which does so by means of virtues such as justice or compassion; transformational leadership, which does so by means of visions or values; and servant leadership which models prosocial behaviours such as stewardship or healing (Vieweg, 2018).

A number of the models seeking to explain altruistic or prosocial behaviour incorporate a role for organisational leaders to some degree (Kanov et al., 2004;

Dutton et al., 2006; Treviño et al., 2007; Lilius et al., 2011; Lilius et al., 2012; Clarkson, 2014; Dutton et al., 2014). In their model of relational responding, Lilius and colleagues acknowledge a significant role for leadership (Lilius et al., 2011; Lilius et al., 2012). They argue that it promotes organisational members' responsiveness to colleagues' suffering by modelling, demonstrating or legitimising the value of noticing pain, feeling empathic concern for those experiencing it and responding compassionately. How they arrange organisational resources to lessen members' feelings of uncertainty or vulnerability about helping forms a part of this (Lilius et al., 2012). Importantly, leaders may have a two-fold role in relation to others' suffering. They can direct employees' attention and empathy to others suffering by modelling such behaviour, or they might control and direct the size, breadth, rapidity or modification of organisationally co-ordinated responses to that suffering (Dutton et al., 2006). According to Clarkson (2014), leaders not only institute organisational social norms regarding the desirability of prosocial behaviour but might also teach staff that these are necessary for the group's success or survival. What this means for organisations is that leaders can play a multi-faceted role in promoting altruism which can be broadly divided into normalising prosociality as desirable or practicably enabling it through their creation of an internal architecture which authorises, supports and resources it.

Prosocial, altruistic or helping behaviour in the workplace is also strongly associated with organisations' construction of internal roles, tasks or routines (Podsakoff et al., 2000; Chahal and Mehta, 2010). For organisational agents the autonomy to undertake extra-role activity or discretionary effort is particularly significant. Job autonomy plays a substantial role in generating prosocial behaviours inside organisations as well as enhancing service quality (Bell and Menguc, 2002). In their study of prosocial behaviour in the hotel industry for example, Lee, Nam, Park, and Lee (2006) found that empowerment had a significant impact on employees' extra role behaviours. Similarly, in a study of business employees, Lee and Lee (2010) found that helping others is more likely when employees feel free to decide whether to help or not. However, conflict or ambiguity generated by one's roles and

responsibilities, as well as the routinisation of those tasks associated with them, can also exert a strong negative influence on prosocial behaviour inside organisations (Podsakoff et al., 2000). What this means for organisations is that those which construct staff roles narrowly, or disempower employees more generally, are likely to reduce altruism within their boundaries (and vice versa). So, altruism as an organisational construct needs to take account of the level of autonomy, or restraint over responsiveness to others, which organisational architecture creates.

Broader organisational pressures may also present employees with constrictive choices between meeting expected levels of task performance and undertaking extra role activities or altruistic contributions (Bergeron, 2007). In a detailed study of work-related stressors and employee altruism, Jex and colleagues found such an effect (Jex, Adams, Barchrach and Sorenson, 2003). They identify a range of organisational constrictions which negatively affect altruism, including reduced budgets, insufficient equipment or materials and interruptions. Contemplating the effect, they argue that these make it harder for employees to meet the requirements of their roles, effectively forcing them to exclude discretionary activity. The factors which they believe are most likely to inhibit altruism are those which restrict performance in some way or oblige staff to adopt trade-offs between different elements of it. However, they did find that levels of affective commitment to the organisation could moderate the process. Organisational commitment itself is an established predictor of altruism (Organ and Ryan 1995; Chahal and Mehta, 2010; De Geus et al., 2020). What this means for organisations, however, is that altruism is likely to be promoted by contexts in which roles are designed to be autonomous and structures or systems allow flexibility. Conversely, those which are more constrictive will create conflicts which inhibit it.[26] For this reason, altruism as an organisational construct needs to reflect the importance of organisationally enabled autonomy as a promoter and organisationally enforced constraint as a potential

[26] They may even create rigidities which encourage more anti-social treatment of users (Zimbardo, 2004; Zimbardo, 2007).

inhibitor. Arguably, it is the extent to which these two opposing forces infuse internal roles, routines and so on that affects altruism rather than those roles or routines per se.

A number of the models seeking to explain altruistic or prosocial behaviour inside organisations acknowledge a role for their design of internal roles and routines (Kanov et al., 2004; Madden et al., 2012; Dutton et al., 2006; Lilius et al., 2012; Clarkson, 2014; Dutton et al., 2014). According to Kanov et al. (2004), in an organisation where job roles are constructed in a flexible manner, and associated responsibilities are wide or broad ranging, staff are more likely to see further than their formal boundaries and act above and beyond their position. By way of a somewhat different example, Dutton et al., (2006) argue that roles or routines which are associated with other-orientated services (such as customer service) can encourage responses to suffering by facilitating attention to pain and increasing empathy or concern for it. According to Madden et al., (2012) new roles and routines which promote action to address others' needs can emerge informally inside organisations in response to suffering. A process is envisaged in which organisational agents who see others' pain or distress modify their roles to notice, feel and respond to that pain, interact with each accordingly to reshape internal norms about suffering and then coordinate amongst themselves to generate compassionate responses. As these are collectivised, the organisation itself will actually change, altering its structure to accommodate such roles, changing its culture to evolve compassionate norms, expanding its routines to include compassionate responding and adjusting its scanning mechanisms so that pain and distress is noticed.

There is an elegance and logic to such models. They explain how and why organisations might generate collective responses to need and coordinate them by means of emerging routines. However, they are perhaps less helpful in organisations where pain and distress are a constant source of background noise, and other-orientated emotions are collectively reduced as a result. Such factors are evident in healthcare (see 3.2). They might also be less helpful in sectors where working outside

of established routines and practices routines is costly, irrespective of whether that benefits members or not. So, the architecture associated with different industries may be relevant in this regard. The architecture of UK healthcare delivery has changed substantially in recent years. Constraining forces include mechanised processes and delivery systems, as well as increased control over clinical activity by means of performance management (Ballatt and Campling, 2011; Campling, 2015). Professional activity has become substantially more routinised, disaggregated, standardised and systematised (Susskind and Susskind, 2015). However, a significant number of failures in patient care have been attributed to the way in which internal systems, processes or routines are operated (Walshe and Offen, 2001; Walshe and Higgens, 2002; Walshe, 2003; Walshe and Shortell, 2004).

Notably, the sector is subject to increased target driven activity and performance management. These can subvert the primacy of patient need, replacing it with the requirement to reach targets or reduce costs (Berwick Report, 2013). The management of healthcare organisations by means of performance measurement systems has been associated with dysfunctional consequences for patient care, such focussing staff on narrower aspects or targets at the expense of more holistic attention to patient need or their welfare as a whole (Mannion and Braithwaite, 2012).[27] What such features do is structurally and systemically reduce the autonomy of what one does, how one does it, when and where to do it, as well as to whom and in what order. Critically, such constraints significantly erode the discretion for altruism which Szulc (2020) identified as individually necessary, but at a systemic or organisational level. Moreover, altruism requires attention to, or appreciation of need, which such constraints may also obviate through a collective narrowing of agents' concentration or the attentional scanning which Madden et al., (2012) say is

[27] There are 12 such consequences arising from poor measurement (measurement fixation, tunnel vision, myopia, ossification, anachronism and quantification privileging), from misplaced incentives and sanctions (complacency, silo-creation, overcompensation, undercompensation, insensitivity and increased inequality), from breach of trust (misrepresentation, gaming, misinterpretation, bullying, erosion of trust and reduced staff morale), and from the politicisation of performance systems (political grandstanding and creating a diversion),' (Mannion and Braithwaite, 2012, p.569).

needed. In healthcare, failing to scan for patient need would erode good care as well as inhibit altruism. Critically, this is an expansion of the regulatory pillar conceptualised by Scott (2003). It may be seen as an increase in this pillar's importance, as well as the driver of increasingly complex rules, regulations and so on, which constrain the autonomy evidently needed for altruism. Certainly, some of the dysfunctional consequences identified by Mannion and Braithwaite might be associated with that. By way of example, fixating on certain targets might arise as a result of external regulation

Another constraint which emerges in healthcare is that of resources. Their relevance to altruism concerns their influence on employees' collective capacity or capability to help, or their perception of such. Transposing the importance of personal resources for altruism identified at the individual level into an organisational context raises questions about the collective abundance or scarcity of internal helping capacity. In UK healthcare, jobs are characterised by high workloads, conflict between different aspects of this and significant time pressures (Ballatt and Campling, 2011). Stressful or strained internal conditions reduce agents' collective cognitive or affective capacity (Leiter and Maslach, 1988; Maslach and Leiter, 2017). Studies show that misalignment between the mental, physical or emotional demands of healthcare roles and the personal, social or organisational resources available to meet them create disengaged, exhausted and emotionally depleted staff populations, who exhibit reduced self-worth (Lee and Ashforth, 1996; Demerouti, Bakker, Nachreiner and Schaufeli, 2000; Zapf, Seifert, Schmutte, Mertini and Holz, 2001; Tsang et al., 2012; Reader and Gillespie, 2013).

Thus, organisations may arrange their architecture in ways which are unconducive to altruism. This is twofold. Firstly, there is their impact on employees' collective personal resource, their personal capacity with which to help others, by means of how work is organised or arranged. Importantly for altruism at an organisational level, structural or architectural features can be arranged or combined in ways which deplete employee capacity. Secondly, there is their control over the provision of

other tangible or physical resources, that is the time, money, colleagues, equipment or facilities with which to help others. Altruism as an organisational construct needs to allow for the possibility that prosocial activity can be undermined by a misalignment between helping need and helping resource. Such misalignment is likely to lessen the belief that one is able to help others at a group or organisational level. There is a question about why prosocial organisational practices do not always emerge as Madden et al., (2012) envisaged even when internal organisational architecture allows an element of freedom and flexibility. Reduced resources, or helping demand-resource misalignment, is one logical explanation of why this might not happen.

Another logical explanation is the extent to which organisational architecture (combined with organisational culture) creates costs or rewards for acting altruistically. Thus, when one is free to act, an associated reward might encourage you to help others, while an associated cost might deter you from doing so. Reward-related patterns inside organisations increase prosocial behaviour when employees value the rewards being offered, see their leaders as controlling those rewards, and believe they are contingent upon behaviour (Podsakoff et al., 2000). However, helping is generally a loss-making activity in which rewards are likely to be outweighed by the combined physical or psychological ones of responding (Latané , Nida and Wilson, 1981). Piliavin and colleagues identify a cost-reward matrix which governs altruism (Piliavin, Rodin and Piliavin, 1969; Piliavin and Charng, 1990; Piliavin, 2009). Within this matrix, the costs of helping include the effort you need to put into it, the harm which might arise out of it, the unpleasant, disgusting or distasteful experiences which might occur whilst doing so and any psychological costs associated with that, such as embarrassment. The costs for not helping include the blame you ascribe to yourself or the censure you receive or expect from others for your inaction. Rewards include praise from yourself or others for helping, or the freedom or capacity to continue with other activities for not helping. For organisations, the cost and reward matrix created by their internal operating environment is likely to have a significant impact on employee altruism. Those which

impose high costs for helping (such as burnout or compassion fatigue) as is the case in healthcare are likely to inhibit altruism.

According to Piliavin and colleagues' model, helping is likely when action is cheap (but inaction is expensive), unlikely when helping is expensive (but inaction is cheap), or open to both possibilities if both choices are costly, when it is likely to be swayed by normative influences (Piliavin et al., 1969; Walster and Piliavin, 1972). Transposing this matrix into healthcare, a nurse might experience a high cost for whistleblowing. A significant physical cost for this might include the loss of one's livelihood or even the ejection from one's industry. There might also be social costs, such as censure or ostracization by one's colleagues. Because patient welfare is being neglected, there would also be a high cost for not whistleblowing, the potential guilt precipitated by inaction. In these circumstances, norms about how patients should be treated might sway the decision to act. However, norms about not undermining one's peers might encourage the opposite. One can see how the scales might work in favour of silence in the absence of any strong moral or ethical convictions. Similarly, not adhering to internal policies and systems which compromise care could come with a high cost, such as negative feedback from supervisors or more formal employment sanctions, whilst adhering to them might create feelings of shame.

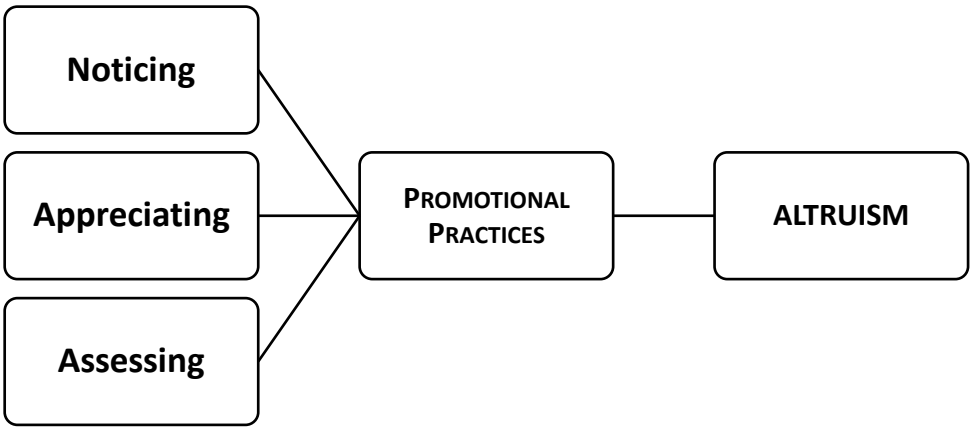
Arguably, an altruistic doctor would dismiss any costs to themselves for acting prosocially without a thought (McGaghie at al., 2002). However, healthcare environments appear to create excessive mental, physical and emotional costs for responding to the need or distress of others. Compassionate or empathic behaviour is not rewarded in this context (Camel and Glick, 1996). It would take a brave professional to ignore internal prescriptions concerning their roles, routines or other expectations such as targets, which appear to take precedence over need in certain healthcare environments. Unsurprisingly therefore, in a study of nurses working in acute care, for example, Slettmyr, Schandl and Arman (2017) found that the costs for altruistic acts, such as criticism from peers, made staff ambivalent about acting,

though they also exhibited a marked sensitivity to rewards, such as feeling positive, being appreciated by patients (or their relatives) or seeing their contribution as meaningful. What is important then for altruism as an organisational construct is the internal structuration of costs or rewards for helping or not. The particular matrix which is created by the culture and the architecture of an organisation that will govern helping interactions.

3.4 Organisational Practices and Altruism

A number of models put forward to explain prosocial behaviour identify the emergence of certain organisational practices or collective behaviours which can promote action to relive another's suffering inside organisations. This section synthesises the main practices which emerge from these models that appear capable of promoting or inhibiting altruism. These are: noticing, seeing or perceiving the pain or distress of others inside organisations; emotionally appreciating that pain or distress in ways which affectively motivate helping; and cognitively assessing those needs in a way which induces a belief in the need to address them (see Figure 6).

Figure 6: Organisational Practices and Altruism



Effectively, altruism should be promoted when organisational members (as a group) are more able to see each other's welfare needs, develop other-orientated feelings

which motivate them to help and judge that it is appropriate to do so. In adopting the term appreciating, it is believed that both feeling and concern are relevant to our affective engagement with others. In adopting the term assessment, judgements concerning both the one in need of help and the one who could provide it are encompassed, as well as assessments of the costs or rewards for acting. In some models, responding is theorised as a practice itself, in others it is positioned as the effect of such practices, a placement adopted here for logical presentation and parsimony.

Starting with the practice of perception, all models of altruistic or prosocial behaviour recognise the importance of noticing another's need in the first place (see Table 1). Schwartz's theory of personal norms, for example, conceptualises helping as a sequential decision-making process which starts with 'attention' (Schwartz, 1973). Importantly, this sequence is activated by need perception, helping unfolds as we become aware of a situation's potential consequences (Schwartz and Howard, 1981).

Table 1: Emergent Altruistic Practices

MODELS	PERCEIVING	APPRECIATING	ASSESSING	RESPONDING
Schwartz (1973)	Attending	Motivating	Evaluating	Helping
Darley and Latané (1968)	Noticing	Identifying	Considering	Acting
Kanov et al., (2004)	Noticing	Feeling		Responding
Dutton et al., (2006, 2014)	Noticing	Feeling	Sensemaking	Acting
Miller (2007)	Noticing	Connecting		Responding
Ballatt & Campling (2011)	Attending	Attuning		Kindness
Lilius et al., (2011, 2012)	Noticing	Feeling		Responding
Way and Tracy (2012)	Recognising	Relating		Reacting

The importance of noticing an event, and classifying it as an emergency which requires action, is a practice which is also identified in bystander models. According to these, potential helpers must (somewhat hurriedly) go through a sequential decision-making process which initially involves noticing an event and identifying it as a situation in which help is needed, however they see the process as potentially inhibited by our reliance on others for social cues or signals that someone's welfare

is imperilled (or not) and that action is appropriate (or not) (Darley and Latané, 1968; Latané and Darley, 1968; Latané and Darley, 1969).

Importantly, what these models indicate is that seeing a situation as one in which another's welfare is being comprised is an essential initial step. There is a primary and precipitating need for situations in which help is required to be recognised as such (Latané and Nida, 1981). However, contextual factors complicate the process and may even draw our attention away from noticing those who need help. The influence of others on our cognition that help is needed, and the attentional or perceptual cues or signals they provide about helping, exert a well-evidenced influence over the recognition process (Fischer, Krueger, Greitemeyer, Vogrincic, Kastenmüller, Frey, Heene, Wicher and Kainbacher, 2011; Fischer and Greitemeyer, 2013; Hortensius and De Gelder, 2014). What this means for organisations, is that employees may rely on their colleagues' behaviours for their interpretation of the need for altruism. So, if peers within organisations send signals that helping is appropriate then altruism should occur, however the opposite should happen if they do not.

This raises some key questions for altruism as an organisational construct. Firstly, what internal factors will affect the cues and signals that help is needed. Thinking of an organisation's cultural fabric, internal norms concerning the need for scanning might play a role in promoting attention to such cues. Thinking of an organisation's relationships, perceptions about the significance or importance of those giving such cues (i.e. as being worthy of attention) might also promote noticing. Thinking of an organisation's architecture, the organisation of this might increase the visibility of those cues and signals that helping is needed, or obscure and undermine them. In a hospital setting, for example, the visibility of patient cues or signals that help is needed might be affected by ward layouts which enable staff to see them easily, or the construction of routines which incorporate more holistic assessments of their condition. The point about need visibility in the physical workplace environment is worth extending.

Need perception is not only enhanced by the clarity or vividness of the need itself, but can also be reduced by any excessive environmental stimulation (stimulus overload) which diminishes its prominence (Shroeder et al., 1995). Studies indicate that noisy distractions which overload our senses, diminish altruism or helping (Sherrod and Downs, 1974; Mathews and Canon, 1975). Importantly, for organisations, uncontrollable stressors such as these can also reduce our interpersonal sensitivity (Cohen, 1980). That may make us less attuned to others' welfare needs or distress signals. So, although the attention-grabbing noisiness of the need or event itself may be important, so is the potentially attentionally-distracting environmental noise which surrounds it. As a construct, organisational altruism should, therefore, take account of the possibility for such noise and interference. An issue for organisations will be what noise they create. At this point such a factor is presumed to arise from a combination of culture and architecture.

The process of noticing is reflected in practically every subsequent model of altruism. Most pertinently for healthcare, Ballatt and Campling identify a process of cyclical kindness in healthcare settings which is precipitated by attentiveness (Ballatt and Campling, 2011; Campling, 2014; Campling 2015). In this model, a prosocial cycle of agent behaviour towards patients follows in which staff attentiveness to patients generates attunement which builds trust between them, generating a better therapeutic alliance that leads to improved outcomes, ultimately fostering a sense of kinship which promotes kindness.[28] Within the model, attentiveness is extremely broad, including noticing, thinking, feeling, learning understanding. Attunement concerns factors such as warm engagement and caring. Critically, Ballatt and Campling argue being more attentively kind to patients itself increases employees' attunement. What all these models usefully indicate is how important the nature of attentiveness is. It is not enough for members to notice need, perceiving events as 'need' will frame altruistic responsiveness from the beginning.

[28] In kindness they incorporate warmth, generosity, sympathy and compassion.

One must, however, ask what factors in healthcare might create attentionally distracting environmental noise that could subvert the attentional element upon which altruism is founded. The literature is somewhat silent on this aspect, but this review indicates that the emotional distress of agents or users might be one such factor. For healthcare, there may be a very particular problem where altruism is concerned, in that traditional signals of someone's need for aid, their shouts, cries or expressions of pain, are both widespread and potentially indistinguishable. So, how can an emergency be visible in a field of emergencies, where distress is endemic? How does one notice need in a sea of suffering? The normal cues and signals which promote altruism may be completely undermined such a context. It is hoped the study can shed light on this. It may be a particularly sectoral feature wielding influence over organisational altruism.

Turning from noticing to appreciating, some of the altruistic practices which emerge from within organisations are affectively formulated. Ballatt and Campling's attunement is just such a feature. However, the most useful depictions of affective practices that promote prosociality come from the field of workplace compassion. Such models concern themselves with how other-orientated actions or emotions emerge and are collectively practiced, propagated and legitimised inside organisations in response to member suffering. While these models also begin with the practice of noticing, this is also followed by a well-defined and clearly articulated practice of feeling. In Kanov and colleague's foundational model in this field, organisational compassion occurs when 'members of a system collectively notice, feel, and respond to pain experienced by members of that system' (Kanov et. al, 2004, p.810). According to the model, processes become collective when they are both legitimated by an organisation's context and widely shared amongst, or propagated by, its members, as well as cooperatively delivered. They argue that collective feeling is more likely to emerge when organisational culture, routines, practices and leadership endorse the articulation or sharing of suffering and less likely in those which force their members to hide or suppress such feelings. Importantly, they acknowledge that organisational features, such as shared values

or set policies, can inhibit the degree to which those inside them see each other's suffering, believe it is deserving of such notice and share their awareness of it amongst the membership.

There is a growing body of evidence to support these patterns which are often termed compassion organising, however in a recent review Kanov and colleagues concluded that empathic responses cannot fully explain how or why compassion develops in some workplaces (but not others) leading them to speculate that organisational uncertainties might do so (Kanov, Powley and Walshe, 2017). They argue that personal, relational and organisational uncertainties will all affect focal actors' uncertainty about suffering and can lead them to miss, avoid or even dismiss cues of others' suffering. Such a feature is intimated in Crawford and colleague's (2014) theory of threat cultures, whereby organisational uncertainties, and the potential for blame or instability they create, reduce collective affective capacity to discern, cope with or respond to other's suffering. For this reason, the highly prevalent instabilities and uncertainties evident in healthcare settings may be another source of attentionally-distracting noise which inhibits altruism. The study may be able to show if this is the case.

Other theorists have extended the Kanov model, albeit retaining the central importance of feeling. In a study of how compassion emerged in the wake of a fire on a university campus, Dutton and colleagues found that students and faculty collectively noticed the fire, exhibited feelings of empathetic concern for those affected and then coordinated action to relieve their distress, organising accommodation, clothes and so on (Dutton et. al, 2006). However, in their model they elevate the prominence of contextual factors in explaining this, with an extended consideration of organisational systems, values, routines and networks. Terming these factors social architecture, they argue that they direct attention to others, aid the development of concern for their suffering and provide the means to obtain and utilise resources to address it. This is one of the few models in the literature that gives real parity to processual and organisational factors.

On the back of a recent review of the literature for such a model, Dutton, Workman and Hardin (2014) extended it further to take account of focal actors' sensemaking in conjunction with those who need help and in response to outcomes. The process is located inside three potentially influential, but increasingly distal domains, which span out from that central process. One includes the actor's personal context, their individual differences or organisational roles. Another concerns their relational context, which includes their similarity or closeness to beneficiaries, as well as any power dynamics. The last is the organisational context, which incorporates shared values, beliefs, norms, any internal practices, as well as leaders and the structure and quality of internal relationships. This modelling gives much greater emphasis to the interaction between potential givers and helpers through sensemaking, which both affects, and is affected, by the central noticing, feeling and acting processes. It ascribes a significant mutuality to need assessment which is missing from other discussions of compassion organising.

Drawing on interviews with a wide range of service professionals, Miller (2007) concluded that compassionate communication between organisational agents and users is underpinned by processes which involve not just noticing a need for help, but also active information-gathering about those who need it and the context within which they are located, leading to the argument that the feeling element might be better framed as a connecting process because of its combination of cognitive elements (i.e. perspective-taking) with affective ones. Framed thus, connecting combines various cognitive aspects evident in Ballatt and Campling's (2011) attentiveness domain, such as learning and understanding, together with some of the affective aspects from their attunement domain, such as empathy. In an attempt to transpose the Kanov model into health and care settings, Way and Tracy, (2012) found evidence to support a refinement of practices into recognising (rather than noticing), relating (rather than feeling) and reacting (rather than responding). Drawing on the practices of nurses, social workers and other care related occupations they argue that noticing practices are too confined to matters of awareness or observation, whereas recognising indicates a much richer

understanding of other cues and features which might undermine them. The argument has merit. Similarly, they felt that feeling is better replaced by relating since that allows for both cognitive connections and affective associations.[29] Both these models helpfully extend the Kanov one with a more distinct (and somewhat separate) delineation of the evaluations which might underpin a decision to address another's suffering as opposed to a desire to do so.

One of the limitations of the models which emerge from the field of compassion organisation is their reliance on those structures which are used to deliver work day-to-day. While this is essential for capturing the multiplicity of internal factors, it does not necessarily yield an understanding of the more dysfunctional elements within organisations which might inhibit responses to other's suffering. Moreover, their emergence from one emotion could be said to hamper their consideration of cognitive matters, such as beliefs or values. If one turns from how one feels to how one thinks, it raises the matter of what other cognitively based practices might emerge inside organisations, and, by being internally collectivised, legitimised and propagated, promote prosociality. Way and Tracy do recognise the need to add a stronger cognitive element alongside affective factors. However, while their combination of these two elements under 'relating' addresses a weakness in affectively based expositions of compassion organising models, conceptualising them separately might make it easier to distinguish between organisational factors which promote or inhibit altruism by means of their impact on our affective qualities or capacities and those which do so by means of their influence on our cognitive qualities or capacities.

Evidence at the individual level, which indicates that beliefs about oneself or others can promote altruism (even if they do not always do so), certainly suggests that there is a strong case for including an evaluating or assessing practice in any consideration

[29] They a prefer (Re)Acting since their studies suggest that the processes are not linear.

of altruism as an organisational construct. A few of the models already explored do seek to explain altruistic or prosocial behaviour to some extent by means of the moral judgements we make about ourselves or others (Schwartz, 1973; Treviño et al., 2007; Kish-Gephart et al., 2010; Clarkson, 2014). Schwartz's theory of personal norms for example, identifies how motivation, which is precipitated by value-based expectations of oneself, leads to an 'evaluation' of the associated costs or benefits of helping which might even prompt thoughts of 'defence' which could inhibit helping (Schwartz, 1973). Along these lines, McGaghie and colleagues' (2002) layer of discernment and judgment, which sits between professionals' compassionate core and the external world, and helps them navigate decisions about the appropriateness of altruistic responses, might be reconceptualised as an evaluational practice. This would make sense given its role in managing altruistic under or over commitment. Drawing on these models, assessing is included as a practice alongside noticing and appreciating, even though it has not been as fulsomely and discretely studied for its potential.

Importantly for such a practice, altruism does not emerge in a vacuum, it is not without interference or resistance. We assess users, who may be collectively valued or devalued inside organisations, as worthy or unworthy of help. We assess ourselves as able to, or responsible for, providing that help. We assess situations as likely to impose costs or rewards upon us for doing so. What is especially important for altruism as an organisational construct, is that there are many ways in which it appears that our evaluation or assessment of helping need can be stymied by organisationally stimulated defensive practices. According to Schwartz's (1973) model, defensive actions absolve us of helping by denying that help is needed, that there is an effective remedy, or that one is able to help and responsible for doing so. In Lerner's just-world hypothesis, one can defend oneself from having to help by distorting one's perceptions of the situation, devaluing the victim or lessening the perceived harmfulness of actions performed against them (Lerner and Miller, 1978). In this way, absolving oneself of censure for moral misconduct can make altruism unnecessary or avoidable. Even if our assessments lead us to recognise a situation

as one in which help is required, we can still evade responsibility by means of defensive evaluations. Studies show that we absolve ourselves of self-censure or blame by: conceptualising our harm of others as having a righteous function; disclaiming responsibility for the harmful effect of our behaviour; or repudiating the value of those harmed (Bandura, Barbaranelli, Caprara and Pastorelli, 1996). Importantly, if the costs of not helping are transformed, altruism may be reduced. The reason this is important is that where such distortions become an integral part of organisational members' assessment practices, it could inhibit altruism.

For altruism as an organisational construct, defensive practices may provide a primary source of explanations for why helping does not occur. In their model, Ballatt and Campling (2011) argue that a cycle of kindness can reduce staff defensiveness. However, defensive practices in healthcare can thwart the very attentiveness or attunement upon which their model stands. In her ground-breaking study of social structured defence mechanisms in hospitals, Isobel Menzies-Lyth (1960) identified nurses' depersonalisation of patients and detachment from their own feelings. The former mechanism is characterised by their denial of patients' significance as individuals, categorising rather than personalising them.[30] Detachment is characterised by their suppression of feelings or attachment to others. Another related practice is splitting up of the nurse patient relationship so that one does not deal with the totality of the patient. These might be called emotionally-detaching or other-distancing practices and are particularly relevant for altruism in their potential to obviate the 'appreciation' of need. They would preclude the feeling or appreciating practices identified in this section. Further practices Menzies-Lyth identified include ritualistic task performance, diffused or generalised responsibility and an avoidance of change. These might be conceived of as cognitively detaching or responsibility-avoiding practices, since they obviate specific ownership of decisions about care or organisation. They would preclude the evaluating or

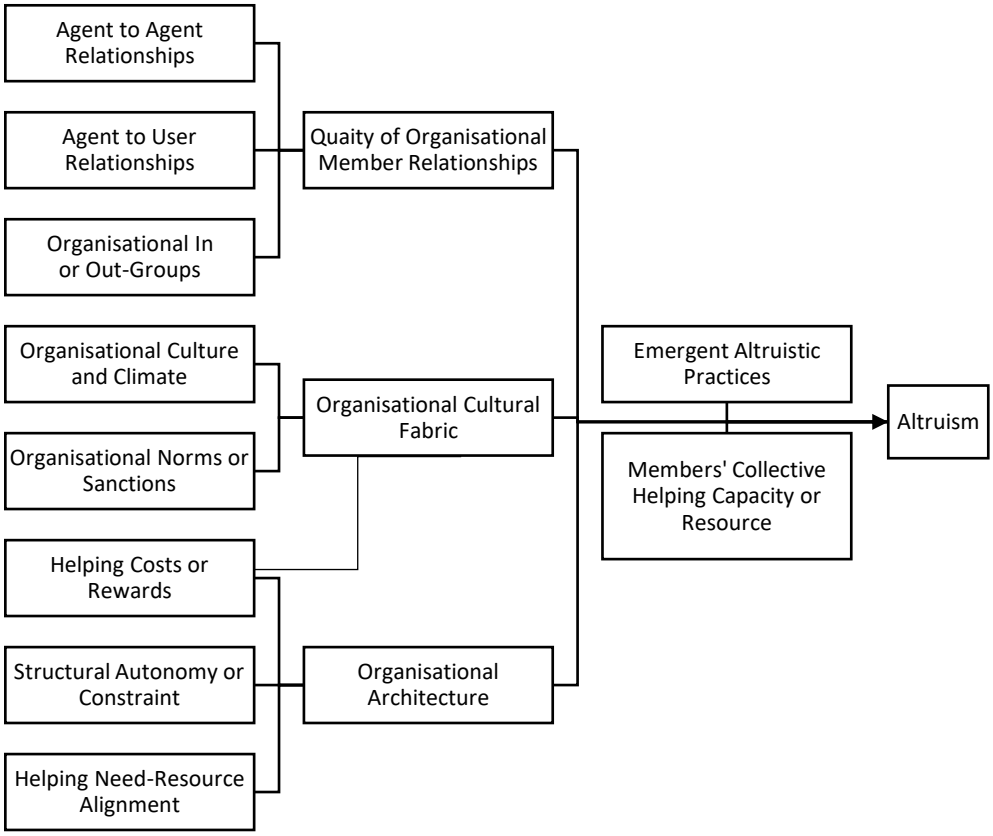
[30] Calling a patient the 'liver in bed ten' rather than by their name is an example.

assessing practice outlined above. Other caring professionals show similar patterns of defensiveness (Krantz, 2010; Whittaker, 2011).

What this suggests for altruism as an organisational construct, is that assessment may be partly characterised by protecting or defending oneself from any calls upon one's resources or obligation to help others. Employees may collectively adopt protective or defensive assessment strategies to minimise the impact of the needs of their colleagues or clients, dampen their feelings about others' suffering and better manage their own anxieties or uncertainties. Thinking of an organisation's cultural fabric, internal norms concerning the worth of others are likely to influence the assessment practice, by the significance (or unimportance) they attach to the needs of different groups, thereby generating positive or negative evaluations of the requirement to help them. Similarly, thinking of an organisation in terms of the relationships between its members, these might create an emotional closeness which alter the significance of such assessments, promoting greater or lesser altruism as a consequence. Thinking of an organisation's activity architecture, the different costs or rewards for helping may influence the outcome of such assessments.

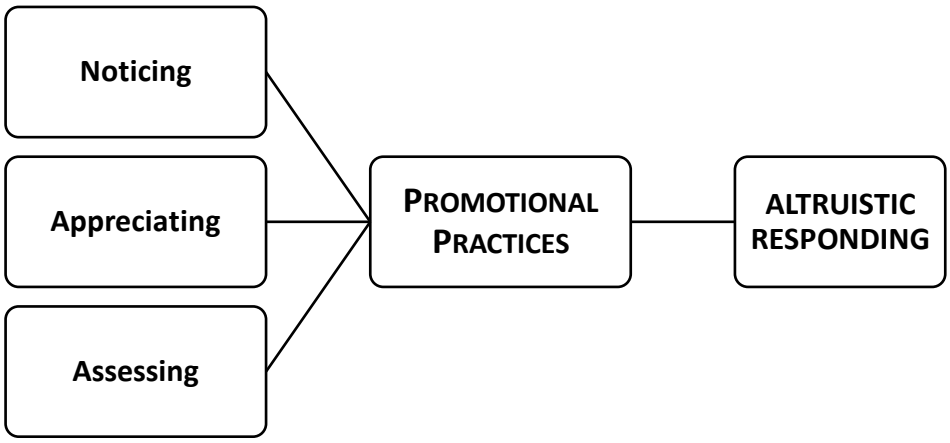
Drawing all this to a conclusion, a number of factors appear capable of promoting or inhibiting altruism within the organisational context (see Figure 7). These include: the quality of relationship between organisational members, which might encourage or discourage helping; the cultural fabric of an organisation, the extent to which its culture, climate, norms and expectations encourage or normalise altruism; and the architecture which structures or governs internal activity, including the extent to which this constrains helping and aligns helping need with helping resources. Costs or rewards, which might make helping expensive (or not), will arise from an organisation's culture and architecture combined.

Figure 7: Organisational Altruism Constructs



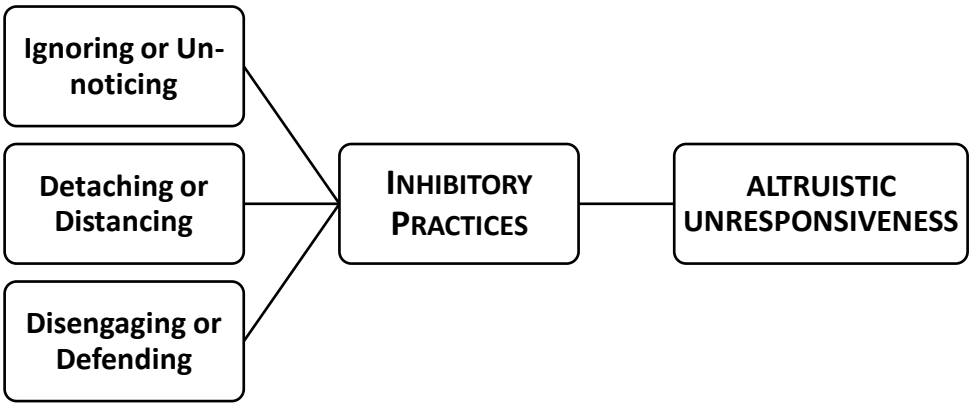
These factors can affect altruism by means of their impact on organisational members' collective helping capacity or resource. They can also stimulate or subdue the emergence of altruistic practices inside the organisational context. The emergent practices which appear most likely to encourage altruism are those in which members are collectively more inclined or enabled to: notice another's need, appreciate it and assess it as worthy of redress (see Figure 8 on the next page).

Figure 8: Emerging Promotional Practices



What is most notably absent from the literature is a model which explains how and why altruism is inhibited. One can speculate from a number of strands in this review that altruism would be inhibited by practices in which organisational members collectively: ignore or avoid other's needs; are or become unable to appreciate or enter into their distress, responding instead with indifference; or eschew any moral or ethical responsibility to respond. These are captured in Figure 9 and provisionally termed ignoring or un-noticing, detaching or distancing and disengaging or defending.

Figure 9: Proposed Inhibitory Practices



A conceptualisation of the combined or collective effect of such practices is not modelled in the literature. This provides a significant gap which this study will focus on addressing. Questions related to this gap which the study may shed light on concern what noise or distractions organisations create which interfere with the visibility of user need and how organisational agents manage that noise in ways which reduce their altruistic potential.

SECTION III

4 CHAPTER 4 METHODOLOGY

4.1 The Choice of a Case Study

This chapter sets out the rationale for adopting a single case study design and explores any pertinent issues arising from that. A case study design is best suited to the author's theoretical intentions and philosophical stance. Easterby-Smith, Thorpe and Jackson (2012), whose definition is adopted, define case study research as:

> 'a detailed investigation…of phenomena, within their context….to provide an analysis of the context and processes which illuminate the theoretical issues being studied. The phenomenon is not isolated from its context….but is of interest precisely because the aim is to understand how behaviour and/or processes are influenced by, and influence context.' (p.323).

Case study methodology supports the author's aim to generate insight into altruism as an organisational construct. As a form, it is particularly appropriate when: context is relevant or pertinent to the subject being studied; situations are complex or unclear; boundaries are blurred, with numerous inter-relationships; and existing theory is not adequate or sufficient (Eisenhardt, 1989; Hartley, 2000; Yin, 2003; Saunders et al., 2009). Such features are evident in the chosen case and field of study where drivers of altruism are complex, unclear and likely to be inter-related. Moreover, existing theory in relation to the study of altruism as an organisational construct is limited. Thus, case study research is a suitable methodology for developing conceptual and theoretical understanding of altruism at this level. In line with the above definition, the method supports the author's desire to develop altruism as an organisational concept, shed light on it in a specific organisational context and illuminate the organisational factors which promote or inhibit it.

This method can lack rigour, be difficult to generalise from or produce results which are long, unwieldy and difficult to read (Yin, 2003). However, case studies are flexible, and able to generate theories which are credible, unbiased and open to testing (Hartley, 2000). If the most common pitfalls of case study research are

avoided, the method can provide a rigorous approach (Pratt, 2009).[31] Moreover, case studies can generate thought-provoking questions, sharpen or illustrate existing concepts and even generate new theories (Siggelkow, 2007). Importantly, building theory from case studies not only helps researchers to understand issues that do not have clear answers but also enables them to tackle grander challenges (Eisenhardt, Graebner and Sonenshein, 2016).

Case study research also suits the author's philosophical stance. Despite sympathising with an objectivist position on reality, the author believes that identifying a single, fixed, identifiable 'truth' is practically impossible, since views about the nature of existence are influenced by human perspectives shaped by psychological and/or situational factors. The author shares the view that objectivity is a label we attach to our own certainty about the world and that the arguments or propositions which we put forward as 'rational' are not so much evidence of what is rational in the world as an attempt to impose our own way of seeing it on others (Haraway, 1988). The author sympathises with the view that 'truth' is socially constructed by those observing it, with the social world created by individuals through their own subjective experiences (Burrell and Morgan, 2005). However, the author does not see the world as created by social actors, but rather as interpreted by them within the ambit of their own experiences. The author believes that individuals are shaped by the situations and systems in which they develop or form their consciousness. On this basis, the author occupies a realistic middle ground between the extremes of positivism and constructionism. Cross-cutting in nature, case study research suits either stance (Easterby-Smith et al., 2012). Moreover, given its ability to work well with either orientation, it is not only suited to the author's philosophical outlook but also appropriate for managing tensions within it.

[31] According to Pratt, the most common pitfalls are striving to make qualitative elements appear quantitative and failing to balance data and theory.

4.2 The Choice of Stafford Hospital

It was a specific case that first attracted the author's attention to the subject of kindness, compassion and altruism. This was the case of Stafford Hospital (Mid Staffordshire NHS Trust). This case was the subject of two national inquiries (one independent and one public), running over a period of seven years (from 2007 to 2013), which investigated events at the hospital between 2005 and 2009. It involved two governments and four Secretaries of State for Health. It is an extreme case which catapulted the subject of kindness and compassion towards patients into the public arena at the time. It has dominated policy-making in health care ever since. Before settling on this case, the researcher considered nine other possible sites (see Appendix 1: Case Sampling). Six were drawn from healthcare. Four were drawn from other sectors for the purpose of contrast and comparison. This review showed that healthcare would be a particularly suitable sector for this work, with significant relevance to the study's chosen subject.

In the UK, healthcare organisations can be conceived of as having an altruistic purpose or prosocial mission, given altruism's position at the core of medical practice (Feldman, 2017) and the National Health Service's (NHS) foundation upon altruistic principles of collective provision for those who need it (Mathers, 2016). As outlined in the literature review, however, in this country there has been a series of 'egregious events' or 'failures' in healthcare organisations followed by major public inquiries over a lengthy period of time (Walshe, 2014; Walshe, 2003). In many of these cases, there has been a significant lack of kindness, compassion or concern for the welfare of patients (Ballatt and Campling, 2011; Crawford et al., 2014; Department of Health, 2012; Neuberger, 2013). Theoretically, within such situations, the inhibitors of altruism ought to more visible.

Of course, there is no single explanation for healthcare failures: rather there is a complex interplay of elements (Department of Health, 2000). The existence and repetition of failures in healthcare may be considered a grand challenge. Solving such

challenges requires an understanding of how effective, and ineffective, human interaction emerges within organisations (Eisenhardt et al., 2016). However, modern healthcare failures share some common themes. They tend to cause significant harm, to be well-known, to be longstanding, to be located in poorly functioning organisations and to re-occur (Walshe and Shortell, 2004). Organisational pathology plays a critical role in such failures, with many showing evidence of poor leadership, ineffective or incomplete management systems, insular cultures and disempowered staff or patients (Walshe, 2014). Some of these concepts, such as leadership, are shown to promote altruistic action. Others, such as insular cultures, have not been considered and may provide new sources of explanation for altruism. There are many barriers to the discovery of these failures, including cultures which foster secrecy and individual or organisational self-deception (Walshe and Shortell, 2004). While this complexity has no bearing on the suitability of a healthcare organisation as a site for this study per se, it does underscore the pertinence and value of case study design, with its ability to develop holistic understanding through the use of multiple lenses, as well as its facility to study the illicit (Hartley, 2000).

Stafford Hospital is also suitable site for this study in its own right. Firstly, it is the most well-known and well-recorded of all of recent cases. As the subject of two inquiries, it also has a considerable volume of data (from a diverse range of lenses) compared to other cases, including oral transcripts from hearings, witness statements from individuals (both in and outside the hospital) and formal exhibits (correspondence, complaints, etc.), which makes it viable from a practical perspective. Moreover, since the two inquiries focus on the organisation as a whole, as well the behaviour of the individuals within it, the data available is broad enough to encompass altruism at all levels, with information about social, contextual and relational features as well as individual behaviours. Secondly, the extensive consternation this case generated about the apparent lack of kindness and compassion shown towards patients receiving care at the hospital makes it suitable in its own right for exploring questions about altruism. The case is one in which the organisation (as a whole), as well as its members (as individuals), was severely

criticised for lacking this, making it theoretically appropriate terrain. Arguably, it may be a 'critical case'; one which according Flyvbjerg has 'strategic importance in relation to the general problem' (Flyvbjerg, 2006, p.229). The alleged lack of kindness and compassion of its employees, which featured prominently in the inquiry, and was highlighted by the media and public commentary at the time, is highly relevant to the general problem of how organisations promote or inhibit altruistic emotions, actions and behaviours, giving it more strategic importance than comparable cases. Thirdly, the extreme nature of the case also offers prospective theoretical value. Extreme cases provide a valuable means of understanding how social actors operate within institutions and use them as a means of oppression (Martí and Fernández, 2013). Stokes and Gabriel (2010) highlight the challenge of understanding the organisational and managerial processes which make genocide feasible, as well as the extent to which those processes apply in other circumstances. Along parallel lines, extreme cases of failure in healthcare are likely to be made feasible by organisational and managerial processes. Understanding those processes may shed light on what factors promote or inhibit altruism in organisational settings.

Finally, a pilot study undertaken using the hospital showed that many of the antecedents for altruism present in the literature could be discerned in Inquiry material. In particular, the pilot showed high levels of help-inducing personal arousal or distress at the individual level (see Appendix 2: Pilot Findings). It indicated that patients and their relatives tended to notice the pain, suffering or distress of others, identify it as requiring a response and (at times) take responsibility for responding. This group also demonstrated a level of empathy towards others. They appeared able to put themselves into another's position and appreciate their feelings. These factors emerged as potential altruistic promoters. Amongst employees, three factors emerged as possible altruistic inhibitors. These were the internal organisational culture, the associated stresses and strains attached to working within it and a perceived lack of support for staff. Overall, the emergence of such themes indicated that the case was a suitable and viable site for the research topic itself.

4.3 Design and Methodology

The study began with some initial concerns, some questions, and a tentative group of constructs drawn from the literature. The main question is 'what factors promote or inhibit altruism in organisations?'. A lack of kindness, compassion or altruism in organisations can harm those they actually exist to serve (their users) or those they employ to serve them (agents). Detecting the features which promote or inhibit altruism in organisations, and developing understanding of them, could identify ways to reduce organisational failures and decrease the harm they cause. For this reason, the author is especially interested in factors which inhibit altruism. The case has been theoretically sampled for its capacity to illuminate such questions. It is considered capable of making the promotion (or inhibition) of altruism visible.

However, single cases have limitations. They may not turn out as expected (Yin, 2003). They can be difficult to generalise from (Hartley, 2000). Despite this, they do capture the complexity of a situation (Johansson, 2003). They can also be tremendously powerful because of their ability to underscore the necessity of the research question, inspire new ideas from the rich immersive research process and illustrate the conceptual analysis being pursued (Siggelkow, 2007). Importantly, single case studies are appropriate when the case itself is unique, extreme or revelatory and potentially suitable for testing established theory (Yin, 2003). Extreme cases are well placed to address grand challenges, because they facilitate research which is rich and deep, advance the generation of insight that typical cases would obscure and help identify means of challenging the underlying problems (Eisenhardt et al., 2016). For that reason, the author believes that a single case is justified for this work. The chosen case has extreme and revealing features capable of illustrating the theoretical terrain under consideration.

The data itself comes from documents and archival records. It includes government reports and organisational materials. To make selection manageable, documents were chosen on the basis of their usefulness in aiding the researcher to trace history,

check facts and counteract biases (Meyer, 2001). The archival records used for this work are those generated by national inquiries.[32] Public inquiries offer a suitable site for case study research, because they provide a significant volume of material which is wide in range, deep in texture and easily accessed (Brown, 2005; Ainsworth and Hardy, 2009). Inquiry reports themselves are a credible source of information about cases, comprehensive in both data and analyses (Herepath and Kitchener, 2016). The data sources for this work were generated by the independent and public inquiries. The data included written statements and their accompanying physical exhibits (e.g. written correspondence, formal complaints) from individual witnesses. Such statements may be considered as falling between interviews or archival records. Such data can provide an understanding of how people think or behave individually, their perceptions or mind-sets, as well as build a picture of how an organisation functions (Yin, 2003). So, they are a rich source for understanding organisational factors.

However, there are problems associated with such data. There are challenges to working with any narrative. Analysis requires considerable skill and diligence, as well as sensitive interpretive work (Boudens, 2005). Inquiries themselves constitute a form of sensemaking, in which different parties may present conflicting narratives in an attempt to impose their own interpretation of events, creating an illusion of agreement rather than consensus (Brown, 2004; Brown, 2005; Brown, 2018). Those undertaken in medical environments may seek to play down the role of medicine generally or its practitioners individually (Brown, 2000). Those concerning healthcare can be characterised by potentially distracting narratives of horror or suffering which detract from causes (Dewar and Boddington, 2004). They can be subject to languages games in which witnesses seek to ascribe legitimacy to themselves or other parties (Kewell, 2006). Moreover, within organisations, different voices jostle

[32] see https://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/

to dominate and control internal narratives, in a constantly shifting and unstable process, while potentially offsetting each other (Brown, 2006).

Brown (2000, 2004, 2005) identifies a number of strategies which can help manage the problem of working with secondary data within an inquiry framework. One is reading and re-reading the material over a lengthy period of time, while becoming more and more familiar with the content and increasingly selective with one's attention. A second is breaking texts down into more easily managed parts, while creating lists of interesting features or categories. Codes adopted should allow for constant comparison of the material, supported by memoranda which explore their textual implications in reference to the questions concerned. A third strategy is adopting a deliberately deconstructionist approach which recognises the dualities present in these narratives. Such dualities might include insider versus outsider or positive versus negative. This strategy is intended to reveal ambiguities and contradictions that must then be teased out by the researcher. A fourth strategy is developing hypotheses gradually while continually questioning the nature of the text and contesting any potential underlying motivational elements inherent in it. This final strategy should help the researcher explore any 'seemingly hermeneutically closed plot' (Brown, 2000, p.50). The study design takes account of these four strategies, which will be referred to here as deep familiarisation, selective categorisation and coding, textual deconstruction and narrative questioning.

The most intensive part of this study involved reading and analysing the witness material. The material is voluminous and coding was a lengthy and complex process. Using the learning from the pilot, the study was modified in a number of ways. The pilot showed the impracticality of reading all texts three or four times and reviewing all material appended to witness statements. This was not unexpected and indicated the need to choose what material to code carefully and judiciously. Steps were taken to ensure that the volume of material would be manageable. Some sampling was adopted. Sixty-eight witness statements were selected from those available. This included those statements available for internal witnesses (patients, relatives,

friends, employees and non-executives), together with a small sample of external witnesses (ten out of a possible 112). This selection is justified on the basis that the focus of the study is on internal matters and external statements were generally concerned with the study of wider healthcare structures and systems at the time. The selection then allowed the researcher to pursue the first strategy of deep familiarisation. It ensured a clear focus on the most relevant material. That material was then read and re-read over the course of the study, allowing the researcher to acquire a more and more nuanced understanding through that immersive process.

The second strategy of developing more and more selective categorisation and coding over the course of the study was also adopted. The author considered both content analysis and grounded analysis for the study. In line with the approach advocated by King (2000), the study drew on predetermined codes from the literature and developed new ones from the data throughout the coding process. When it comes to the data analysis, given the complex nature of the precipitating case, grounded theory could be suitable because it is good for capturing complexity, linking research with practice and investigating areas that have not been well explored (Locke, 2001, cited Bryman and Bell, 2007). Reviewing data without prior constructs allows constructs to emerge, but this does not fully align with the researcher's interest in enhancing existing theory. Content analysis provides the opportunity to interrogate data with previously defined constructs. However, these approaches do not have to be a stark choice, they can be a continuum along which to place a study (Easterby-Smith et al., 2012). Both are used for this work, adopting a middle-range approach between content and grounded analysis. Thus, witnesses' statements and other data was coded against a set of defined constructs drawn from the literature, whilst freely emerging codes were also captured during the process. This generated a set of initial first order codes that were, over the course of analysis, amalgamated into a more abstract set of higher-level themes from which a scheme of narratives was produced (see Appendix 5a: Code Summary and Appendix 5b: Complete Code Amalgamation).

The pilot was a key means by which the initial approach to coding was tested. It drew on a diverse combination of informants, witnesses with different roles from different tiers of the organisation.[33] [34] These were chosen to test the richness of material, and work with the range of witnesses available to identify tensions from their respective positions within the inquiry, comparing and contrasting different perspectives accordingly. Initially, statements were read without coding to become familiar with the data. This step indicated the immense volume of data. Some statements ran to three hundred pages, with numerous attachments. It confirmed that the case was a viable site, showing statements to be a rich source of material and highlighting the presence of a small number of highly significant (but unanticipated) stories. As a second step, statements were freely coded. This demonstrated the potential for a large number of emerging codes.[35] It demonstrated that emerging themes could be a source of antecedents or counter-arguments not located in the literature. It also revealed that themes could be either positive or negative.[36] Thirdly, statements were reviewed using predetermined codes from the literature and categorised in relation to the dimensions drawn from analytical models or frameworks.[37] This provided a comprehensive set of codes for the study.

Case study research requires parameters for summarising, categorising and structuring data in a logical way (Saunders et al., 2009). Pertinently, since case studies generalise through analytical or theoretical propositions rather than through statistical ones, it is important to have a logical means of linking your data to your propositions and rational criteria for interpreting your findings (Yin, 2003). The

[33] These were: a patient, Anonymised Patient 02; a relative, Anonymised Relative 19; a nurse, Anonymised Employee 23; a doctor Anonymised Employee 15; and a non-executive, Anonymised Non-Executive 01.
[34] To aid the comparison of the witnesses, codes were created to identify the organisational tier in which they were located as well as their role or perspective. The final codes for organisational tiers are executive, expert, external individual or organisation, inquiry, non-executive and professional. Those for roles are board member, doctor, friend, manager, nurse, other employee, other role, patient, regulator, relative and senior executive.
[35] It highlighted a number of themes which had been strongly identified in the literature, such as 'time', as well as some, such as 'fear' which were not so prominent.
[36] For example, there were 19 references to 'fear', all of which negative, however there were eight references to 'speak out', three of which were positive and the rest negative.
[37] During this step, statements were cross referenced to ensure that the free codes generated from the second readings were captured for all five witnesses. Any codes considered vague or unclear were tightened or combined. For example, references to time (e.g. time, lack of time, etc) were combined into one theme.

author drew strongly on the literature to create such parameters for categorising, structuring and comparing the data in a thematic way, to provide this logical linkage. Importantly, case study research differs from other forms of qualitative research in being more open to guiding analysis through the use of conceptual categories or theories (Meyer, 2001). Using an iterative approach, the literature review was organised in various phases (see Appendix 4: Literature Review Process). The first one familiarised the researcher with the scale and scope of the literature, showing that a multidisciplinary approach to altruism was needed. A second phase identified showed that a large body of altruistic research, for example that relating to non-human altruism, would be irrelevant. The first two phases indicated that there were individual, contextual and social or relational approaches to altruism, all of which would need to be explored. A third phase was undertaken alongside the pilot study to refine the core constructs for the study. Importantly, the emerging codes from the pilot often supported constructs in the literature codes. They also fleshed out understanding of them and brought out narrative nuance and dualities. Engagement with the literature then continued alongside the data analysis in order to address these nuances, iteratively generating understanding of the emerging themes. In this way, constant cross-fertilisation between the two sets of codes was used to drive the strategy of increasingly selective categorisation advocated by Brown (2000).

In the pilot, some codes from the literature were less evident than expected, suggesting the need to ensure all constructs were systematically and consistently coded for. So, additional steps were taken to aid the consistency and comprehensiveness of the coding process. Template analysis was the main means by which case data was structured. Ideally suited to the author's philosophical approach, template analysis can be used with either epistemology, being 'located at the interface between content analysis (predetermined codes) and grounded theory (where codes emerge during the analysis)' (Easterby-Smith et al., 2012, p.165). Three different templates for manually collecting this data were tested through the pilot. These may have worked if the volume of material had been less. However, given the scale of data, the pilot identified the need for a different approach. For this reason,

coding was undertaken electronically through NVivo, using a single standard template of all codes. This enabled data to be more easily searched and annotated than the manual process originally envisaged would have allowed. Shifting data capture from a manual to an electronic process allowed for the creation of number of table formats to facilitate the retrieval and analysis of data coded in the NVivo database (see Appendix 6: Data Output Samples). However, to ensure consistency of coding, a printed copy of the template sheets for both literature codes and emerging codes was used when undertaking coding activity. This also helped to reduce the potential for duplicating codes. Finally, a coding tracker was created to track changes and ensure internal conceptual coherency of the overall set of codes throughout the process (see Appendix 7: Coding Tracker Excerpt)

Turning to the witness data itself, a deliberately deconstructive strategy was adopted for textual analysis along with narrative questioning. To support this a number of number of elements were identified which might combine to affect the narratives in this particular case. Firstly, the motivation of unconscious emotions was acknowledged; emotions might influence witnesses' statements or prompt them to act in certain ways. Although those involved in this case merit our compassion, some caution should be exercised when drawing conclusions from their statements. People's perspectives are not neutral. Any observer, whether involved in the inquiry or not, could be tempted to interpret events or their own role within them in a way which is psychologically reassuring. Witnesses might be experiencing a range of emotions prompting them to act, think or feel in a particular way in an inquiry setting. They could be feeling guilt or self-recrimination. The situation itself (as opposed to the specific witnesses) also merits caution. People have personal and professional conceptualisations of themselves, as well as reputations, which they wish to protect. The stories they tell may be underpinned by a desire to reassure themselves about their own character and behaviour which could compromise the telling. Similarly, protecting the reputation of your organisation may be a means of protecting yourself. This is a possible limitation of the study.

Such factors had to be kept in mind whilst analysing statements. Witnesses who were relatives or carers, in particular, might feel a sense of personal omission for harm done to their relations, and thus be motivated to cast events in a way that minimises their exposure to such feelings. They might also be experiencing anger, feeling motivated to punish those who they feel harmed, or failed to prevent harm to, their relatives. Analysis of such statements had to be treated with caution and sceptical enquiry. Theoretically, employees in such a highly public case of abuse might also wish to disassociate themselves from the practice it indicates or minimise their involvement in it. Of course, this does not mean that the factors employee witnesses identify are automatically suspect or invalid, but one must, at the very least, acknowledge the possibility that their recollections, assessment or sense-making might be more focussed on external factors outside of their control as opposed to internal ones within their own ambit. It might be natural for any witness in this position to recollect mitigating factors, or contextual constraints, more strongly.

Being an employee of a publicly criticised institution inevitably generates strong feelings. Staff witnesses were employed working for a hospital which is now internationally known for failing to provide proper care for patients. In this position, they might (in retrospect) wish to explain or justify their own behaviour to themselves as well as others. They might be inclined to ascribe responsibility to external factors such as other individuals, patients, colleagues, managers and so on, or contextual features, such as time, resources, and so on. They might also want to bring to light any barriers to providing good care that they experienced, including others' behaviour towards them. Alternatively, employee witnesses might be feeling guilt or self-recrimination over a sense of personal omission in relation to their professional practice or willingness to complain at the time, and thus potentially be motivated to cast (or retrospectively recast) events in such a way which minimise any painful feelings this engenders. They could also be experiencing anger, directed towards those who put them in the spotlight or aided in the creation of events, and thus potentially motivated to punish them. Anger might be especially likely for

whistle-blowers who made complaints that were not addressed. Those who complained or blew the whistle might have been emotionally depleted by the experience, possibly prompting feelings of moral outrage and a desire to punish those who retaliated.

Such dangers can be partially mitigated with the data itself. Using the full range of inquiry material, including witness statements, contemporary records and formal complaints helped to counteract problems of retrospective sense-making or protective recasting. Some mitigation was possible through cautious analysis and careful study of conflicting views, drawing on a wide range of alternative perspectives to uncover where emotions could theoretically influence witnesses' statements and prompt them to re-interpret events with hindsight in an inquiry setting. Additionally, it was possible to address the potential biases inherent in witness statements by contrasting a varied range of these from patients, friends, relatives, employees, non-executives and external parties. Comparing them helped to counteract biases through an investigation of their differing perspectives. However, narratives still had to be carefully analysed with a level of scepticism, to deconstruct individual motivations.

To assist with this, a set of specific coding specific questions was created. This was intended to ensure that potential motivations or interpretations would be identified and could then be questioned or challenged (see Table 2 on the next page). These questions were used whenever a coded theme was identified in the text. So if, for example, a theme such as compassion was identified, further questions would be asked, such 'who is identifying the presence or absence of compassion' or 'what perspective do they hold' and so on. Questions would also then be prompted about why they, in particular, held such a position, whether it was common amongst their in-group and to what extent it was supported by other in or out-groups.

Table 2: Data Coding Questions

	DATA CODING MOTIVATIONAL CHALLENGES
1	Who is involved in (or articulating) the situation (their tier within the organisation).
2	What is the perspective of those involved in (or articulating) the situation (their specific roles within the organisation).
3	What actions are those involved in (or articulating) the situation performing.
4	What actions are those involved in (or articulating) the situation seeing others performing.
5	How are those involved in a situation related or relating to each other.
6	How are those involved in (or articulating) the situation behaving.
7	How are those involved in (or articulating) the situation perceiving others as behaving.
8	How are those involved in a situation feeling or thinking about events.
9	How are those involved in a situation perceiving others to be feeling or thinking about events.
10	What organisational routines, systems or processes are involved in this situation.
11	What other contextual features or situational effects could be identified.

Going through this process ensured that contrasting narratives were consistently taken account of and questioned during the analysis. It also helped to ensure that any ascriptions which witnesses were making about other individuals were also challenged. Whether events were considered positive or negative (or both) was built into this process. This identified some key dualities in the narratives.

The validity of the approach is considered to lie in its ability to reveal certain charged self-protective or defensive narratives amongst those using or working at the hospital. By way of example, employee witnesses refer to a wide range of alternative explanations for the situation at the hospital which could be said to recuse them from responsibility and absolve them of guilt. These narratives can make another source liable or culpable for the situation at the hospital. The various rationalisations are set in Table 3 (on the next page) to illustrate the effectiveness of the approach in teasing out such narrative strategies. These were taken account of when testing findings in the final analysis.

Table 3: Rationalising Unhelpfulness

	SOURCES	RATIONALISATION	NARRATIVE
1	PERSONAL LIMITS	Agents were not able to act (i.e. they are time constrained) or responsible for acting.	I am not to blame as I was unable to act.
2	FINANCIAL LIMITS	Agents lacked the resources with which to act. This limited, constrained or undermined their ability to act.	I am not to blame as I lacked resources to act.
3	EXTERNAL LIMITS	External rules or regulations constrained agents' ability to act, skewering their actions or focussing them elsewhere.	I am not to blame as others outside the organisation constrained me from acting.
4	INTERNAL LIMITS	Internal goals or expectations constrained agents' ability to act, skewering their actions or focussing their attention elsewhere.	I am not to blame as others inside the organisation constrained me from acting.
5	INJURIOUS INTENTION	Action by agents was not required. The problem is partly fictional or non-existent and criticism is politically motivated.	I am not to blame; others were blaming me maliciously.
6	INACCURATE PRESENTATION	Action by agents is not required. The problem is created by inaccurate, unbalanced or exaggerated reporting.	I am not to blame; others were blaming me falsely.

Alongside these coding questions, a number of models were used to supported the analytical challenges of potentially charged narrative data. A preliminary model or organisational altruism was produced from the literature to assist with categorisation. This model was used in two ways during the analysis. Firstly, narratives which emerged from the case could be compared against it to locate the source of promoters or inhibitors. Secondly, from this process, any specifically organisational elements will be captured. As well as using this model created from altruistic constructs in the literature, the author also drew on other organisational models and analytical frameworks to help describe and categorise the data, organise it around themes or topics and identify patterns or groupings within it. This provided a basis for analysing data, making thematic comparisons and interpreting findings.[38] Other models were used as a means by which to manage the analytical challenges of the study, by providing diverse and conflicting ways of looking at data which would

[38] The author set up an expert panel to generate further insight should it be necessary but dispensed with this after careful consideration of the findings. A case write up was also deemed unnecessary.

challenge the author's perspective or prejudices and illuminate tensions in the data. During the pilot, four such models were tested for their usefulness as a means of categorising and structuring the data and assisting with the analysis of themes. One was Gabriel's poetic modes model, as a means of analysing stories for their protagonists, characters, plots, predicaments, poetic tropes and emotions (Gabriel, 2000).[39] This model proved extremely useful. It was effective in assisting the author with their analysis of stories and narratives, proving particularly useful for illuminating witnesses' emotions and attribution of qualities to themselves or others in their narratives. Consequently, it was used in the study. Another was Brief and Motowidlo's (1986) Typology of Prosocial Behaviours. This proved somewhat promising during the pilot for identifying relevant organisational routines and practices which might promote or inhibit altruism. For this reason, the behaviours were incorporated into the coding template.

The author also tested Keller and Price's (2011) Organisational Health Index as a clear way of structuring the data in relation to organisational culture, contexts or features. This provided a comprehensive list of the constituent elements (or parts) of organisations which could be used to consistently categorise, structure and analyse data along organisational lines.[40] Though validated as an instrument of assessing the health of organisations (Keller and Price, 2011) it proved difficult to apply, generated

[39] His model includes a full framework of: characters (including those of deserving victim, fool, non-deserving victim, hero, love object, trickster, villain, supportive helper, rescue object, assistant, villain, gift-giver, lover, and injured or sick person); plots (including misfortune as deserved chastisement, underserved misfortune, trauma, achievement, noble victory, success, love triumphant, misfortune conquered by love); predicaments (including accident, mistake, coincidence, repetition, the unexpected and unpredictable, crime, insult, injury, loss, mistake, misrecognition, contest, challenge, trial, test, mission, quest, sacrifice, gift, romantic fantasy, falling in love, reciprocation, recognition; poetic tropes (including providential significance, unity, agency before misfortune, denial of agency during misfortune, malevolent fate, blame, motive, agency and credit); fixed qualities associated with these (including nobility, courage, loyalty, selflessness, honour, ambition, gratitude, caring, loving, vulnerability, pathetic, pomposity, arrogance, vanity, being decent, worthy, good, devious or mean); and lastly emotions (including mirth, aggression hate, scorn, sorrow, pity, fear, anger, pathos, pride, admiration, nostalgia, envy, love, care, kindness, generosity, and gratitude).

[40] The model has nine elements of organisational health, which are: 'direction', 'leadership', 'culture and climate', 'accountability', 'coordination and control', 'capabilities', 'motivation', 'external orientation', and 'innovation and learning,' (Keller and Price 2011, pp.34-35). Each element has a number of management practices which underpin it (37 in total). For example, one element of organisational health which may be relevant in this case is 'external orientation.' This has four management practices underpinning it, which are 'customer focus,' 'competitive insights,' 'business partnerships,' and 'government and community relations,' (Keller and Price 2011, p.35). The model has clear descriptors for each of these management practices. The practice of customer focus, for example, is described as 'understanding customers and responding to their needs,' Keller and Price, 2011, p.35).

little understanding and was discounted. Lastly, the author tested Morgan's Organisational Metaphors (Morgan, 2006). This identifies eight metaphors for thinking about organisations.[41] This model proved difficult to apply, with few instances identified during coding. However, it occasionally assisted in generating a richer understanding of more charged narratives and was incorporated into the coding process on the assumption that it might enable the author to identify and explore any starkly contrasting ways witnesses positioned or made sense of events. The additional value of this model is that it provides diverse lenses for viewing organisations in fresh, novel and contrasting ways, together with metaphors that can be used to generate new insight or theories (Morgan, 2006). Thus, it supported the author's interest in developing theory, as well as challenging the author's own way of thinking about organisations.

4.4 Summary

The work takes the form of a single case study: an approach suited to the consideration of complex phenomenon in organisational settings. It incorporates questions (and concerns) about what factors promote or inhibit altruism in organisational settings. The chosen case itself was theoretically sampled for its capacity to answer those questions. The main sources of data are the public and independent inquiries. Five inquiry reports, three summaries of oral evidence, two expert reports, one regulatory report and sixty-eight witness statements were used. Witness data was analysed using organisational models and constructs drawn from the literature, supported by a template of predetermined codes. In addition, emerging codes which appeared relevant to the study questions were opportunistically collected. The author overlapped data collection and analysis and iterated continuously between case data, emerging theory and the literature. When analysing the data, the author captured themes, events and stories using

[41] These are as: 'machines', 'organisms', 'brains', 'cultures', 'political systems', 'psychic prisons', 'flux and transformation', or 'instruments of domination' (Morgan, 2006).

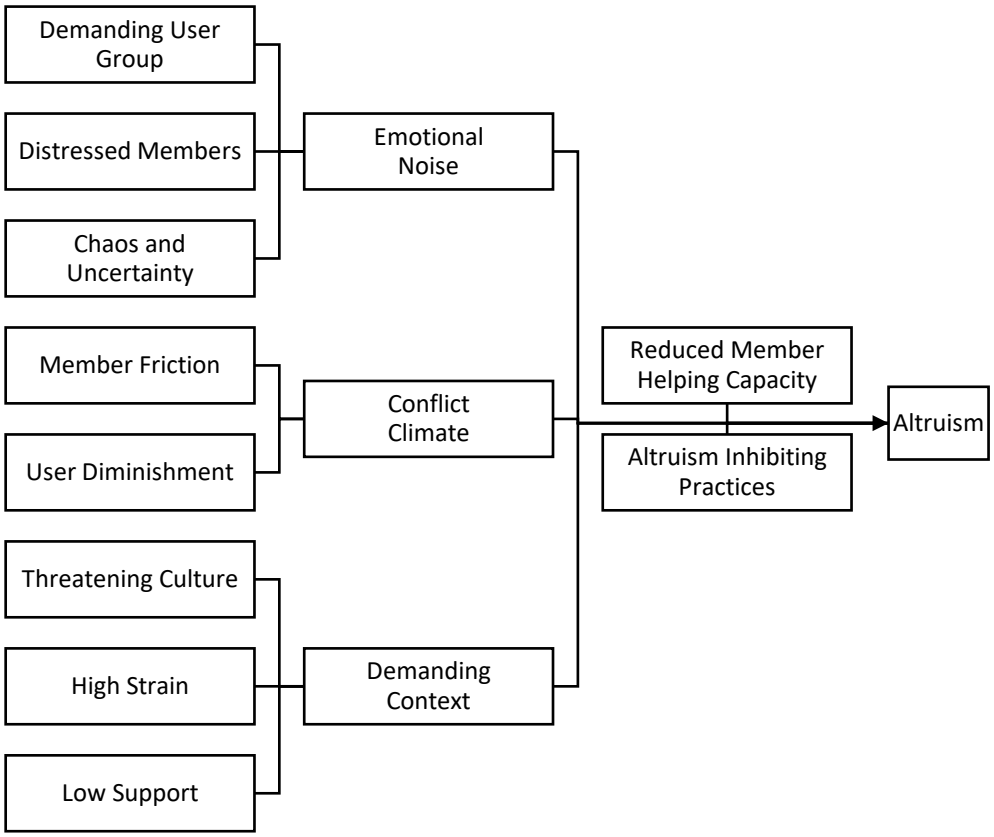
predetermined codes for altruistic constructs (from the literature) and created additional codes for any new or emerging themes relevant to the study questions. The study exploits the full value of an inductive approach, drawing on: a deep immersion in the case to comprehend all its aspects; theoretical sampling to illuminate conceptual features; and grounded theory building processes. The author adopted a 'flexible' and 'opportunistic' approach to data collection, overlapping data collection with data analysis and undertaking iterative comparisons of the case data, the theory emerging from it and the literature. Iterating between constructs and (multiple sources of) data helped the author to hone constructs, tighten their definitions and build evidence to support them.

SECTION IV

INTRODUCTION

The four themes which emerge most strongly in this case are an emotionally noisy organisation, a climate of conflict between organisational members, a significantly demanding organisational context and unresponsive organisational agents (see Figure 10). Above all, the hospital is a site of extensive emotional noise, characterised by a high level of user need, distressed members and organisational uncertainty.

Figure 10: Organisational Narratives



Foremost among narratives is the pain, suffering and distress of organisational members. Members are broadly comprised of the hospital's user group, which includes its patients as direct users and their friends or relatives as indirect users, as well as organisational agents, which includes staff, managers, leaders and non-

executives. The term organisational agents will be adopted when referring to staff as a group. The term organisational users will be used when referring to patients and their relatives as a group. At times, the terms patients, relatives, managers, employees and so on, will be used when the more discrete aspects of these groupings are relevant. The term organisational members will be adopted when referring to both agent and user groups together.

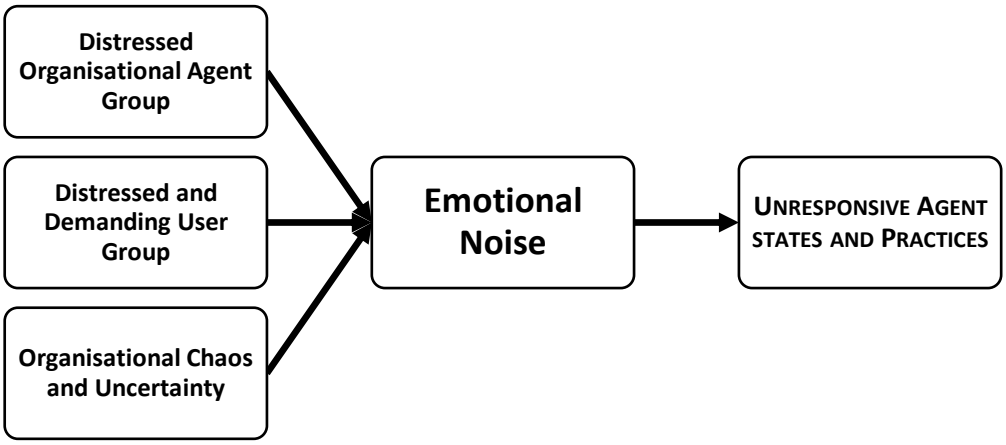
The two groups are, at times, excessively aroused. That is partly caused by users' condition, partly by agent practices and partly by internal organisational conditions. The emergence of emotional noise as a factor indicates the importance of givers and recipients' moods, emotions or affective states in promoting or inhibiting altruistic or helping behaviour. It is explored in Chapter 5 of this section. The climate of conflict within the hospital is characterised by friction between organisational members and the derogation or 'diminishment' of organisational users. It is explored in Chapter 6. The emergence of conflict as a factor indicates the importance of internal organisational relationships and social structures. The demanding context within the hospital is characterised by a high strain on organisational agents, coupled with low levels of support for them with which to meet those demands. It is explored in Chapter 7. Its emergence demonstrates the importance of contextual constraints for altruism.

These factors combined reduce organisational agents' collective helping capacity or resource. They also precipitate practices amongst them which are unconducive to altruism. Those practices are agents' avoidance of users' needs, their inattentiveness or indifference towards users themselves and their deterrence of users from approaching them or seeking their help. Such practices are explored in Chapter 8. Their emergence shows how organisational agents become disengaged or detached from users. In this case, that leads to their not noticing or seeing users' needs or distress, not appreciating their condition or situation and consequently, not assessing the need to help them. This is an organisation-wide effect in which such practices align to make user need less noticeable or significant.

5 CHAPTER 5: AN EMOTIONALLY NOISY ORGANISATION

Distress is one of the most prominent aspects to emerge in this case. The articulation of organisational members' pain, suffering and distress is foremost among narratives. There is a marked pattern of arousal in the hospital, characterised by strong moods, emotions and affective states. Emotional noise arises from that distress, as well from as broader threats and uncertainties (see Figure 11).

Figure 11: Emotional Noise in the Hospital



As will be seen in this section, users are distressed by illness, its treatment and associated indignities, while employees are distressed by workplace conditions and organisational threats or insecurities. Collectively, the distress of both groups creates extensive emotional noise and strong affective tension.

5.1 A Distressed Organisational User Group

Significant levels of patient distress are evident in this case (see Appendix 8a: User Distress Narratives). Unsurprisingly, patient distress arises from the pain or suffering they experience as a result of their condition. Hospital users exhibit a natural fear of illness, as well as anxieties concerning its treatment. By way of some typical

examples, patients are depicted as 'terrified' or 'extremely fearful'.[42] [43] Relatives exhibit similar feelings as a consequence of seeing a family member's illness or injury. They talk of being 'frightened' and 'upset' by their kin's pain and suffering, as well as their own uncertainties about what is happening.[44] [45] [46] Relatives, in particular, articulate extremely strong and intense emotions. By way of examples:

> 'I put my hand on my Mum's head and I filled up with tears because my hand didn't fit round the lump on my Mum's head.' [47]

> '…she was in agony….. My Mum was in absolute agony, I can hear her screams now, as I walked into the ward.' [48]

These last two instances Illustrate how distressed patients create a population of extremely aroused relatives. For them, a family member's suffering is highly noticeable and perceived as significant. Understandably, it is as an emergency. Importantly, in such cases, users' distress is precipitated by their own situation. Healthcare is characterised by inevitably distressed users. In this way, the strained internal emotional terrain of the hospital is partly attributable to the structure of the sector itself.

A second source of user group distress is the way patients and their relatives are treated by the hospital (see Appendix 8a: User Distress Narratives). Treatment deficiencies are systemic. There are deficiencies in the organisation of hospital systems, processes or routines. These are characterised by delays, uncertainty and confusion. Next, there are deficient attitudes amongst those operating these systems or delivering services. Some organisational agents exhibit a lack of concern for patients or indifference towards service users as a whole. Then there is the deficient management of patients themselves. Their progression through clinical

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[42] Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.45.
[43] Relative, Independent Inquiry, Summary of Oral Evidence, Week 1.
[44] Relative, Independent Inquiry Report, Volume 1, par54, p.65.
[45] Relative, Public Inquiry, Anonymised Relative 09 Witness Statement, par9.
[46] In witness statements pages and paragraphs are usually numbered, but sometimes omitted.
[47] Relative, Independent Inquiry Report Volume 1, par70, p.70.
[48] Relative, Healthcare Commission Report, par25, p.56.

pathways, or any ancillary caring processes that they require, is poorly organised or administrated. The latter feature is partly characterised by organisational agents' apparent neglect or abandonment of patients and partly characterised by chaotic and uncertain organisational conditions.

Concerns about such deficiencies are widespread amongst users. By way of example, a patient explains how waiting for three hours for pain relief or help was ' traumatic and stressful' for them and their family.[49] Along the same lines, a relative explains how waiting for cancelled treatment was 'extremely worrying' and 'distressing'.[50] [51] Systemic inadequacies generate significant affective tension, amplifying an emotional terrain which is already strained by anxieties about illness. Some examples which illustrate the point are:

> **'**I had to keep asking for his syringe-drivers to be refilled when they emptied. It just didn't seem to be a priority. On two occasions, I waited for over an hour for a reply to the call-button and eventually I just had to go and find a nurse and insist that they left the patient they were with to come and help... He was crying by that time and in great distress.' [52]
>
> 'I noticed that the urine container under the bed was full and needed emptying……there was also a dirty nightie under the bed, which had obviously been either concealed or forgotten. I found [REMOVED] sitting in her own urine more than once. The bed was wet through. Whenever I asked nurses to come and change [REMOVED], I was upset.' [53]

Instances such as these indicate a neglect of users as people who are frail or vulnerable, and as patients who are suffering pain and discomfort. Notably, treatment is often delayed, with patients experiencing a prolonged state of 'waiting' or discomfit. This intensifies or exacerbates the distress which they are already

[49] Patient, Independent Inquiry Report, Volume 2, p.346.
[50] Relative, Independent Inquiry, Summary of Oral Evidence, Week 2.
[51] Independent Inquiry Summaries of Oral Evidence have neither page nor paragraph numbers.
[52] Relative, Independent Inquiry Report, Volume 1, p.394.
[53] Relative, Public Inquiry Report, Volume 3, par25.22, p.1604.

experiencing as a result of their sickness. It also distresses their relatives. By such means, user distress may be deepened as well as lengthened and protracted, contagiously affecting other hospital users, both related and unrelated to them. For example, one patient says she was:

> 'bubbling with anxiety about what would happen to older people at the hospital.' [54]

Systemic deficiencies amplify an already noisy emotional terrain created by sickness. Notably, however, the distress they precipitate cannot be attributed to the structure of the industry. Rather it is being caused by how the hospital itself organises and delivers its systems, processes and routines, as well as the behaviour of its agents in delivering them.

A third source of user group distress is the indignities which patients experience as a consequence of their physical state, vulnerable position or disrespectful treatment by organisational agents (see Appendix 8a: User Distress Narratives). This includes them being placed or left in degrading or humiliating situations, such as naked or undressed in public view. It also includes their being derogated, disrespected or dehumanised. By way of illustration, relatives talk of how there was 'no dignity' or 'no respect for the patient's dignity'. [55] [56] This is generally accompanied by strong negative moods or emotions, such as shame or embarrassment, anger and outrage, or shock and horror. Illuminating examples are:

> 'She was absolutely shocked at the way a consultant would speak to a patient in the ward, would speak quite loudly so everybody could hear….. didn't pull the curtains round or speak in low tones.' [57]

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[54] Patient, Public Inquiry, Anonymised Patient 02 Witness Statement, par6, p.6.
[55] Relative, Independent Inquiry Report, Volume 1, par206, p.109.
[56] Relative, Independent Inquiry Report, Volume 2, p.26.
[57] Relative, Independent Inquiry Report, Volume 1, par211, p.111.

> ‘Everyone could have seen her. That is why I was so distressed because my Mum would have been horrified if she would have known that people were walking past and could see her. The door was just left open all the time.’ [58]

What such instance show is that the position which organisational systems place patients in heightens their vulnerability and, in doing so, precipitates extremely strong affective responses from family members. Again, this escalates emotional noise.

Consequently, relatives go on to make negative judgements about staff. Their narratives indicate that their moral beliefs or emotions are also aroused. They condemn events as ‘awful’ or ‘dreadful’. They express strong beliefs or personal convictions that patients are being inappropriately treated or positioned. In one illuminating example, a relative describes a family member as follows:

> ‘He felt demeaned. He lost a lot of his dignity, his pride. There was so much taken away from him that – it was just unbelievable to see a man that was so full of life brought down to the – to the state that he was in, that he was frightened to say anything or to be able to stand up to people.’ [59]

The use of ‘unbelievable’ carries a sense of moral reproof. It shows a normative schism whereby user expectations are at odds with organisational practice. As well as noticing the patient’s predicament, and emotionally appreciating it, this relative assesses agent practices against their own expectations of care, or the caring process, and finds them wanting.

Importantly, where indignities are concerned, it is not the structure of healthcare which is the source of such distress, nor is it the hospital’s operation of its systems and routines per se. Rather it is their operation in conjunction with the attitudes of those operating them which causes distress. To illustrate this point more fully:

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[58] Relative, Independent Inquiry Report Volume 1, par21, p.55.
[59] Relative, Public Inquiry Report, Volume 3, par23.10, p.1501.

> ‘he couldn’t get to the toilet in time so he was in a wet bed. That is distressing enough anyway, let alone for a 77 year old that do [sic] not walk. The loss of dignity that he experienced was just awful; it was really embarrassing for him.’ [60]

> ‘there was a lovely old man in the bed opposite. He obviously had some type of dementia, but he was very gentle and kind, I witnessed him having to wet himself. He was all dressed up in a suit ready to go home. He begged and pleaded for the nurse to bring him the toilet bottle, but she said “You'll have to wait, I'm dealing with so and so's patient”. It would only have taken her a moment…. There wasn’t a curtain round him or anything. It was heartbreaking. There was no dignity. I will never forget it.’ [61]

Examples such as these reveal a set of noticing, appreciating and assessing practices which organisational users adopt in response to the undignified treatment of patients. Firstly, they notice patients’ situations and perceive them as undignified. Importantly, such events are ascribed considerable significance. Secondly, they enter into patients’ situations, displaying an ability to appreciate their perspective. This encompasses: perceiving patients’ physical incapacities, such as immobility or incontinence; recognising patients’ personal vulnerabilities, such as their aged state or dementia; and identifying any associated emotional states patients are experiencing, such as fear or embarrassment. The lexicon which users use, for example words such as ‘heart-breaking,’ indicates compassion towards those suffering. By way of a third step, users assess the situation, expressing judgements which indicate that they see patients as worthy and agents’ actions as misaligned with what patients deserve. Patients’ worthiness is indicated by terms such as ‘kind’, ‘gentle’, ‘gentlemen’. Agents’ unhelpfulness is condemned by words such as ‘awful,’ ‘embarrassing’ and a ‘loss’.

It appears important that users do not just notice other users’ distress. They also enter into, or appreciate, it. They demonstrate concern for patients’ physical symptoms, their pain, diarrhoea, incontinence, weight loss, and so on. The also show

[60] Relative, Public Inquiry, Anonymised Relative 20 Witness Statement, p.12.
[61] Relative, Public Inquiry, Anonymised Relative 11 Witness statement, par11, p.4.

concern for their human frailties, such as their age or mortality. And they pick up on patients' moods and emotions. To illustrate such sensitivities, relatives talk of how their 'father's mental and emotional state was extremely low'[62] or 'patients were very anxious and distressed'.[63] Importantly, users recognise patients' mental or emotional states and attach significance to the fact that they are distressed. In this, they are displaying other-orientated perspectives and other-orientating emotions, both of which would be conducive to altruism. Alongside this appreciation of patients' distress, users also appear to undertake situational assessments of their predicament. As a result of such assessments, they judge patients' distress to be legitimate and see their dependency upon others for help as valid. By way of example, one patient describes how:

> 'it was worse, I thought, for the old lady next to me, who couldn't get out of bed, and who was a very ill lady.' [64]

Such assessments generate the belief that patients, as members of their group, are being poorly treated. This prompts users' condemnation of organisational agents as responsible. Such conclusions are the resulting of their noticing, appreciating and assessing other users' welfare.

To summarise, the evidence of users' pain, suffering and distress in the data is substantial. Unmanaged, it creates an internal terrain which is emotionally noisy and affectively tense. Critically, it is a collective feature with in and out-group effects. Hospital users are not only grieved or pained by their own illness, treatment deficiencies or indignities. They are also sensitive to, or concerned by, how others within the user group are treated by the organisation. Thus, patients become distressed at seeing other patients' pain or suffering. Relatives become distressed at seeing the pain of those with whom they have no relationship. Users, as a group,

[62] Relative, Independent Inquiry Report, Volume 2, p.311.
[63] Relative, Independent Inquiry Report, Volume 2, p.313.
[64] Patient, Public Inquiry Report, Volume 3, par23.11, p.1501.

notice the pain, suffering or distress of members, enter into it, and appreciate its significance or importance, as well as assess it as worthy of redress.

5.2 A Distressed Organisational Agent Group

In this case, organisational agents also display high levels of personal arousal. However, different factors provoke this. In their case, the main triggers are their own challenging workplace demands or context, the difficulties faced by their colleagues within the same environment and broader organisational insecurities (Appendix 8b: Agent Distress Narratives).

Starting with the first of these, in the same way that organisational users are distressed by their physical situation as patients, organisational agents are distressed by their professional, occupational or employment situation. They are conscious of the effects of this upon them mentally and emotionally. For example, they speak of being 'upset', 'worried', 'stressed,' and 'dispirited'.[65] [66] They describe their working context as having a deleterious psychological impact upon them. By way of an example, one doctor explains how they felt 'exposed and vulnerable', as well as 'uncomfortable at being forced to cut corners'.[67] Another describes nurses as being 'very uncomfortable' and working 'outside their comfort zone'.[68] Along the same lines, a nurse talks of feeling 'very exposed and vulnerable'.[69] Agents do, in their statements, occasionally mention how patients feel.[70] However, there are far fewer instances of them picking up on the pain and distress of patients. So, the most prominent potential helpers in this situation appear conscious of their own vulnerable position. The direction of their attention to their own situation in this way is important for altruism.

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[65] Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par67, p.18.
[66] Doctor, Public Inquiry, Witness Statement Anonymised Employee 18, par19, p.6.
[67] Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par43, p.10.
[68] Doctor, Independent Inquiry Report, Volume 1, par74, p.204.
[69] Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par27, p.9
[70] The Healthcare Commission (2009) reports that some were distressed at being unable to deliver appropriate care (or spend enough time) with patients.

A second cause of agent distress is the occupational situation of their peers, members of the agent in-group (see Appendix 8b: Agent Distress Narratives). They are sensitive to the challenging circumstances faced by their individual colleagues. They also perceive them to be poorly situated or treated as a group. In articulating this, they speak of doctors experiencing 'continual discontent'[71] or having 'lost heart'.[72] By way of a typical example, one doctor describes how most hospital consultants were 'unhappy' and articulated this, but were 'ground down' nonetheless.[73] Similarly, agents describe the nursing population or group as 'under a lot of stress'.[74] A pattern emerges in which agents perceive the situation of their peers as difficult and appreciate the emotional distress which that causes them. This is not the strongest theme in the case. Nor is intense distress always evident in such examples. However, there is a shift of focus from self to other, with the direction of organisational agents' attention appearing to be anchored onto their own in-group.

Sympathy or concern for their colleagues' predicaments is strongly implied in this. Such instances indicate an ability to enter into a colleague's situation, a capacity to appreciate their position or perspective and a sympathetic orientation towards them. Arguably, in line with the literature, those who perceive the pain and suffering of peers as members of their in-group should feel compassion for them (Mathur et al., 2010). This should promote altruism. However, in this case such feelings do not appear action-orientated. Instead, they indicate a sense of pity towards colleagues, a sympathetic recognition of their situation, underpinned by a level of passive resignation. That resignation might indicate acceptance of the situation which their colleagues are in. However, one could also see such descriptions as a means of articulating a level of cynicism about one's own problems. Agents might be seeing their own difficult position reflected in that of their peers. Colleagues' treatment might be reminding them of their own. Thus, one could see an agent's narration of

[71] Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par37, p.10.
[72] Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par3, p.2.
[73] Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par3, p.2 .
[74] Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par48, p.13

a colleague's difficulties as an expression of their own suffering. Irrespective of this, whether for oneself or others, pity is still likely to contribute to the affective fabric of the organisation. Importantly, it focuses the direction of organisational agents' attention onto their peers' negative state, or their own, rather than on patients' negative states.

A third cause of organisational agents' distress is organisational threats or insecurities (see Appendix 8b: Agent Distress Narratives). The hospital's internal terrain is both unsettled and unsettling. Organisational insecurities include internal organisational changes, such as new targets, system changes or ward reconfigurations, as well external organisational changes, such as new rules, regulations or requirements. Other destabilising uncertainties are financial instability, in the form of deficits and budget cuts, and staffing alterations, such as redundancies or restructuring. The latter are clearly intertwined. Notable insecurities which agents articulate include the prospect of failing to fulfil their roles or meet organisational expectations, the potential for being blamed as a result of that failure and the possibility of adverse repercussions or retaliation. By way of example, one manager speaks of how staff were 'fearing for their jobs' as a result of internal structural changes.[75] Pertinently, they go on to explain that:

> 'A "fear factor" mind set was created when the workforce reductions came in, as people's jobs were not safe and everybody became wary.' [76]

Another manager reveals how such matters focus agents inwardly. Talking of internal upheavals they say 'people were concerned about how it would affect them personally'.[77] Drawing on instances such as these, one can discern an emotional pattern amongst organisational agents which is characterised firstly by their experience of negative emotional states, such as fear or anxiety, and secondly, by

[75] Manager, Public Inquiry, Anonymised Employee 11 Witness Statement, par31, p.9.
[76] Manager, Public Inquiry, Anonymised Employee 11 Witness Statement, par32, p.9.
[77] Manager, Public Inquiry, Anonymised Employee 09 Witness Statement, par52, p.17.

the direction of their attention inwards towards their own position as a result of those affective states.

Extending the point further, a pattern emerges in which organisational agents appear deeply conscious of organisational insecurities. They articulate a state of unsettling ambiguity and distracting turmoil. Their awareness of this is associated with uncomfortable or disturbing mental or emotional states. As a result, they appear to perceive the internal culture and environment as threatening. They present themselves as exposed by organisational forces and express generalised anxieties about the prospect of negative events occurring as a result of such forces. These factors would affect all those working at the hospital, whether they articulate them or not. The pattern is pertinent because it affects those who have the most visibly prominent roles within the organisation as helpers. It is possibly one of the strongest potential altruistic inhibitors in this case because of how it directs employees' attention to their own, potentially self-absorbing, negative state. Cognitive or affective capacity to appreciate or assess users' needs would be lessened by this.

When the distress of both users and agents is considered in combination, a pattern emerges in which emotional noise is exacerbated by systemic neglect and unresponsive organisational practices. Within the hospital any member can help another member. Though organisational agents are not the only people in this situation who might aid others, they are the parties best placed to help users. However, in this case there is a noticeable cycle in which internal conditions stimulate agents' adoption of introspective stances and kindle inwardly-orientating emotions. That, in turn, precipitates unresponsive behaviours towards users. These behaviours then provokes further distress amongst users as a group. Thus, distressed agents generate more distressed users. To explain the process, an employee who is worried about their job security might become more and more absorbed by that and consequently less and less attentive to patients. In turn, patients' relatives may be angered by their behaviour and react indignantly. That could lead to tense exchanges

which might exacerbate the situation further. Such a pattern would escalate internal emotional noise.

An example of that cycle is evident in the operation of the hospital buzzer system. This is a site in which affective tension is evident. Unresponsiveness towards patients is evident in the neglect of buzzers. This appears to be common or normalised organisational practice (see Appendix 9: Buzzer Routine). Such neglect may be a response to emotional noise or a means to manage its impact upon agents. However, it is also a potential source of continued affective tension. Buzzers are a means of communication which support the formal relationship between users and agents within the hospital. They mute the noise which would arise from patients having to call out for attention, obviating the need for their shouts or cries which would otherwise contribute to an emotionally noisy internal terrain. They should reduce emotional noise within the hospital. However, there is substantial evidence that employees fail to answer them. A tendency for buzzers not to be 'heard' or 'responded to' was a significant feature of the organisational environment (Healthcare Commission Report, 2009). The Trust was in the worst 20 percent of hospitals for the time taken to answer them in the 2005 Patient Survey.[78]

This pattern of neglect increases emotional noise. Firstly, it replaces the ostensibly neutral technical sound of buzzers with more emotionally or negatively toned shouts and cries of distress as patients' main means of attracting attention. By way of example, one explains how:

> 'several patients in his bay buzzed for nursing staff but no one came. Instead, the patients had to shout to attract the attention of the nurses.' [79] [80]

[78] Independent Inquiry Report, Volume 2.
[79] Patient, Independent Inquiry, Summary of Oral Evidence, Week 2.
[80] When relatives see buzzers unanswered they seek aid, for family members or unrelated patients. Their response to buzzers is robust illustration of the way in which helping behaviour occurs within the hospital without the benefit of a personal connection or family relationship. For them, emotional noise appears to prompt help-giving or seeking.

A second feature of this neglect is that it can exacerbate patients' conditions when their symptoms are neglected, or result in further injuries and embarrassments as they try to manage their own needs or help other patients without the aid of organisational agents. For example:

> 'He would also come in and find me lying in my own vomit, urine, and on one occasion, I was suffering from severe violent diarrhoea. I had been buzzing for some time as my Stoma bag had burst. I was embarrassed and ashamed when my mum walked in to see me in that state.' [81]

> 'she would sound the buzzer and it would just go off and off and off and then the same – it was the same thing, she would just call out for the nurse. When the nurse did come, she would be put on to the commode and it was obviously too late. The nurse would put her back into the bed, you could hear her – she would wait on the commode for half an hour and very often she would just try to make it herself and just go smack on to the floor.' [82]

As these examples show, unnecessary distress arises from the additional complications caused by such neglect. In this, it is not the structure of healthcare itself which is creating the distress, rather it is the in-operation of organisational systems.

A third consequence of buzzer neglect is that because they not being answered for protracted periods of time, the strength of patients' shouts and cries intensifies in aural and emotional intensity. By way of a highly illustrative example:

> 'After about 20 minutes you could hear the men shouting for the nurse, "Nurse, nurse", and it just went on and on. And then very often it would be two people calling at the same time and then you would hear them crying, like shouting "Nurse" louder, and then you would hear them just crying, just sobbing, they would just sob and you just presumed that they had had to wet the bed. And then after they would sob, they seemed to then shout again for the nurse and then it would go quiet …'[83]

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[81] Patient, Public Inquiry, Anonymised Patient 01 Witness Statement, par15, p.5.
[82] Relative, Independent Inquiry Report, Volume 1, par14, p.53.
[83] Relative, Public Inquiry Report, Volume 3, par23.8, p.1500.

What such instances show is that staff adopt inattentive practices which exacerbate the emotionally noisy organisational environment. Not being responded to heightens users' emotion and intensifies their affective signals. As a result, the organisation is creating a user population that is even harder to manage due to the increased level of emotional distress which being unattended to stimulates. Collectively, the distress which arises from this will be significant. Importantly, patients' inability to secure help by means of a system designed to communicate their needs, is likely to: exacerbate feelings of distress associated with their condition going untreated; precipitate anxiety about whether they will be treated or not; and prompt anger or outrage amongst those observing the process. As a result, escalating user distress is likely to inject more and more emotional noise into the situation. This is pertinent and problematic since it increases the emotional demands placed upon staff within the workplace, some of whom might already be experiencing reduced affective capacity.

5.3 Emotional Noise Conclusion

Analysis of pain and suffering in the hospital reveals a site of significant emotional noise, created by a highly distressed and emotionally demanding user group, as well as a distressed and affectively strained agent group. Internal organisational instability and uncertainty also contributes to the effect. User distress, in particular, creates significant emotional noise. Some of that distress has no internal organisational basis. It arises from patients' conditions. One should recognise that the structure of the healthcare industry is relevant in this regard, because of its inevitably distressed user population. However, much of the noise is also created by internal factors. One such factor is how organisational agents collectively (as a group) act towards patients (as a group). Both their attitudes towards patients, and their treatment of them, are perceived as deficient. Another organisational factor is the systemic deficiency of internal systems, processes or routines established to treat users. Combined, such factors elevate the distress which patients are already

experiencing as a result of their sickness, thereby intensifying internal emotional noise.

In this case, organisational agents' and users' distress arise from very different sources within the hospital (see Table 4). They also respond very differently. Agents perceive themselves made vulnerable by organisational forces or pressures and exhibit negative emotions as a result. Organisational conditions induce an inward focus, anchoring their attention on themselves or their in-group. Being both aware of, and potentially absorbed by, their own negative state blocks or reduces their capacity to perceive or appreciate users' distress. Their attention is diverted or distracted. As a result, collective internal capacity or helping resource would be reduced. That would be unconducive to altruism towards users because it reduces the likelihood of their needs being noticed or perceived. As will be seen later in this section (Chapter 8), agent distress is also accompanied by a pattern in which they are inattentive towards patients and avoid them.

Table 4: Sources of Organisational Emotional Noise

	TRIGGER	DESCRIPTION
1	HEALTH CONDITION	Users are aroused or distressed by their own (or others') illness and associated pain or suffering.
2	HEALTHCARE TREATMENT	Users are aroused or distressed by how they themselves (or others) are treated (physically, clinically or emotionally).
3	SITUATIONAL INDIGNITIES	Users are aroused or distressed by the indignities they experience or perceive patients experiencing.
4	WORKPLACE CONDITIONS	Agents are aroused or distressed by their experience within the organisation, their personal or professional situation (and/or interaction with others).
5	COLLEAGUES' SITUATION	Agents are aroused or distressed by colleagues' experience within the organisation, by their peers' situation (and/or interaction with others).
6	ORGANISATIONAL INSECURITIES	Agents are aroused or distressed by perceived contextual threats and insecurities within the organisation.

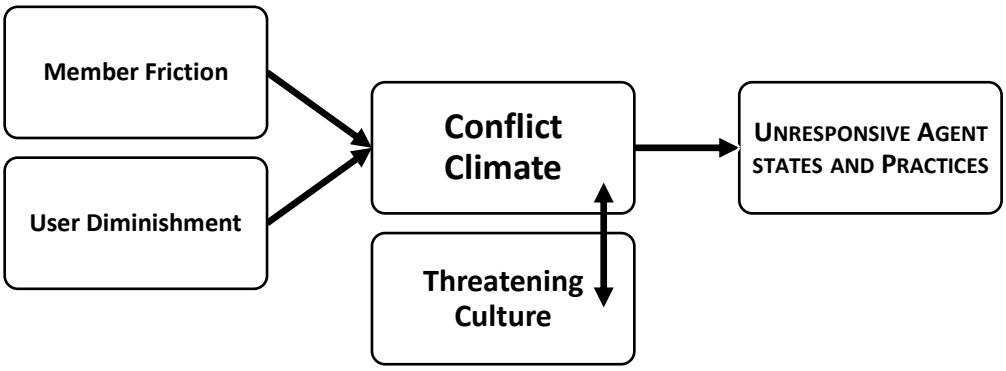
By way of an illuminating contrast, emotional noise is also clearly accompanied by a pattern in which users (as a group) pay attention to patients' pain, suffering or distress, exhibit concern for them and respond. It is natural for family members to

respond in this way. However, there is a noticeable group effect. Users who see such inappropriate practices towards unrelated patients are also emotionally aroused. Moreover, they judge patients' states or conditions as wanting, and condemn those whom they consider responsible for treatment of their in-group which does not meet their norms or expectations. This provokes angry responses which escalates internal affective tensions and promotes reparative responses to redress the wrongs. Such factors would promote altruistic or helping behaviour towards other users.

6 CHAPTER 6: A CLIMATE OF CONFLICT BETWEEN MEMBERS

Another prominent narrative to emerge from this case is a climate of conflict. In the hospital high levels of friction or relational tension are evident amongst organisational members. This can be seen between the two main organisational groups, as well as within the agent group between managers, staff and peers. Alongside intense member conflict, there is also evidence of the derogation or diminishment of organisational users (see Figure 12). This chapter considers these two narratives.

Figure 12: Member Conflict in the Hospital



In the hospital, friction between agents and users is stimulated by: deficiencies in the clinical aspects of care, for example diagnostics, treatment, or medication; deficiencies in the personal aspects of care, such as grooming, toileting assistance and so on; and deficiencies in the attitudes of those delivering both of these aspects. The feelings which such deficiencies stimulate include: other-condemning emotions, such as anger, contempt or disgust; moral indignation, ire or outrage concerning one group's perceived ethical breaches towards another; and more day-to-day expressions of irritation, annoyance or displeasure. The practices associated with this friction include avoidance, where organisational agents ignore or eschew users, and deterrence, where they rebuff or reject them. Notably, this conflict also

contributes to the threatening culture evident within the hospital explored later in this section (see Chapter 7). It does so by helping to create a culture in which users feel unwelcome or unwanted and agents feel insecure or threatened.

6.1 Friction between Organisational Agents and Users

In this case, conflict between organisational agents and users is extensive (see Appendix 10: Member Friction). It is characterised by a number of features. Firstly, there are unfriendly or unwelcoming attitudes towards users. Secondly, there are general incivilities between the two groups. Thirdly, there is outright hostility, antagonism or aggression. Such hostility may be actively and overtly articulated, or more passively and covertly expressed.

Starting with the first of these features, the hospital culture or climate is one in which users perceives themselves as unwanted or unwelcome. By way of one highly illuminating example, a relative narrates how:

> 'The staff were so unapproachable there. It was just the looks they gave when we came back in.' [84]
>
> '….it was the eye roll, the tutting from the nurses that I remember, it was not what they said, it was the way they used to say it. It was the attitude and the looks and I can still remember that.' [85]
>
> 'I recall hundreds of instances of raised eyebrows or the flick of the head from the Hospital staff.' [86]

This relative is picking up on organisational agents' visual cues and signals, their facial expressions, non-verbal signs or gestures and body language. These instances indicate that agents are making users aware that they are not welcome or wanted, without speaking or acting. Instead they are conveying this through their general

[84] Relative, Public Inquiry, Anonymised Relative 01 Witness Statement, par40, p.12.
[85] Relative, Public Inquiry, Anonymised Relative 01 Witness Statement, par25, p.8.
[86] Relative, Public Inquiry, Anonymised Relative 01 Witness Statement, par36, p.11.

demeanour or deportment. What the relative determines from all this is a sense of agents' unapproachability. It implies that they should not be asked for help.

Turning to the second feature of conflict between agent and users, the relationship between these two groups is also characterised by low level clashes or generalised incivilities. There is substantial evidence of interaction between them which is inconsiderate or discourteous (see Appendix 10: Member Friction). Agents are characterised as curt, abrupt, off-hand or brusque. They are described as 'rude and dismissive' 'uncommunicative' or 'extremely abrupt'. [87] [88] Low level clashes are also evident in depictions of agents' semi-audible expressions of annoyance, for example huffing, puffing and so on, or descriptions of their non-verbal actions, such as flouncing out, banging doors and so on. Typically, one relative describes an employee thus:

> 'she huffed and she puffed and she banged the door and she left … She just walked off'[89] and 'she seemed quite angry … So she flounced out.' [90]

What users determine from this is a sense of agents' antagonism. Again, it implies that they should not be asked for help.

Extending the description of incivilities, the tensions between agents and users is also characterised by condescending or patronising attitudes. Agents are shown mocking or belittling users and behaving patronisingly or condescendingly. For example, one patient explains how they were stunned by the attitude of a consultant who said: 'Now you've had your bed and breakfast, you can go home'.[91] In a particularly illuminating example, a relative explains:

> 'I found the nurses' approach very patronising….They were very flippant and

[87] Patient, Public Inquiry Report, Volume 2, p.22.
[88] External Organisation, Independent Inquiry Report, Volume 2, p.131.
[89] Relative, Independent Inquiry report, Volume 1, par295, p.134.
[90] Relative, Independent Inquiry Report, Volume 1, par15, p.154.
[91] Patient, Public Inquiry, Anonymised Patient 03 Witness Statement, par42, p.12

> were clearly just paying lip service to the issues. They were extremely patronising and asked me if, once I had got over my grief, I would be prepared to provide training to their nursing staff. I was outraged.' [92]

In instances such as these, users are undermined or lessened in some way. In one, the implication is that the patient is a 'malingerer', there for personal benefit rather than sickness. In the other, a relative's grief is characterised as a potential source of benefit to the hospital, as a training tool. Users' 'stunned' and 'outraged' responses, indicate their anger or indignance towards those perceived to be making light of their situation.

Flippancy or humour concerning organisational users' pain and suffering as patients or as people is also evident. By way of example, one relative recalls that:

> 'the nurses were horrible at the time. They were laughing at patients who weren't able to do anything for themselves.' [93]

Along similar lines, another relative explains how her husband was not only 'very upset' to have heard a nurse 'joking about her predicament' but also to have found out that this was typical.[94] Another speaks of how her husband explained to her that 'nurses were talking and laughing about the patients'.[95] The humour in these instances is perceived as disrespectful. Critically, staff are laughing 'at' or 'about' patients and the predicaments that their illnesses cause them. Such a pattern indicates that even if employees perceive a patient as vulnerable, they do not have to appreciate, or enter into, their situation, nor assess it as deserving of respect or redress. Humour may be a means by which agents dissipate their irritation, or assuage themselves of guilt for being unable or unwilling to help users. However it also escalates friction between these two groups.

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[92] Relative, Public Inquiry, Anonymised Relative 07 Witness Statement, par42, p.10.
[93] Relative, Public Inquiry, Anonymised Relative 12 Witness Statement, par28,p.9.
[94] Relative, Independent Inquiry Report, Volume 2, p.259.
[95] Relative, Public Inquiry, Summary of Oral Evidence, Week 3.

Turning to the third feature of conflict between organisational agents and users, relationships between them are also characterised by more vigorous forms of hostility. The manifestation of such hostility is twofold. Firstly, agents are shown being directly and actively hostile towards those who need or seek help. Examples which illustrate this include:

> 'she was due to go on a break, and he said to her: I'm really sorry but I have done it, and with that she exploded. She threw the urinal down on to the bed and she pushed his trolley up against where he was with his dinner and she went out and she never came back.' [96]

> 'a very, very stroppy sister threatened to have me thrown off the ward altogether because I was being very emphatic in wanting to see somebody who had information as to what was the matter.' [97]

This manifestation incorporates instances of organisational agents reacting angrily with physical aggression towards perceived demands placed upon them by users. Examples which typify this are:

> '[REMOVED] told his wife that he had asked a nurse for help to go [sic] the toilet but the nurse had got angry before leaving to find a bottle. [REMOVED] was not able to wait and he told his wife that the nurse had 'exploded' and threw either the urinal or the food tray onto the bed and left.' [98]

> 'his daughter told the Inquiry that a nurse came in and literally threw documents at her that she said she would need for the funeral.' [99]

Instances in the data, such as those above, depict staff abusing users verbally or physically. The latter is evident in examples of staff throwing urinals, food trays, or documents at users in ways that suggest intense anger or frustration and a lack of mental or emotional control. These actions imply that employees are over-stretched and over-whelmed, or are able to see themselves as such. What follows is a common

[96] Relative, Independent Inquiry Report, Volume 1, par15, p.154.
[97] Relative, Independent Inquiry Report, Volume 1, par281, p.130.
[98] Patient, Independent Inquiry, Summary of Oral Evidence, Week 1.
[99] Patient, Independent Inquiry, Summary of Oral Evidence, Week 3.

pattern or process. Firstly, patients seek aid or assistance, or their relatives do so on their behalf. Next, agents rebuff them for doing so, by verbal or non-verbal means. This leads hospital users to persist. Events then escalate. That can even result in overt bullying or aggression. Agents' angry outbursts could, in this context, be seen as an unconscious attempt to re-assert control or address their own powerlessness. However, it is likely to deter organisational users from seeking help. As a consequence it protects agents from calls upon them to help others. It is a conflict riven power-struggle which is unconducive to altruism.

A second way in which hostility is manifested is by means of more indirect, covert or passive action. In these situations, agents appear to project their frustration onto users through subtler, less direct, but still aggressive means. By way of some examples:

> 'I went to see one of the nurses to explain that I thought it was something more serious and the nurse said to me "if you don't think it is a panic attack, you find out what it is" and gave me a medical book to look through.' [100]

> 'they had a basket at the end of the bed that they would put sheets into, and we would go in and they were covered in urine, and they were covered in faeces and the smell. And we would constantly drag this out and put it outside of the room and said: please, would you not leave this in my Mum's room because all of the germs are airborne and they are – as soon as we had gone, it would be put straight back in again.' [101]

The first example might be seen as an employee expressing their aggression towards a 'demanding' relative indirectly by telling them to diagnose the patient. One can conceive of there being unspoken implication that 'if you so know much why don't you do my job'. The second is a kind of dance in which both parties engage in hostilities indirectly through the placement (and replacement) of linen baskets. Such behaviours could deter help-seeking. By such means the presentation of need is blocked or reduced. That would inhibit altruism.

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[100] Relative, Public inquiry, Anonymised Relative 19 Witness Statement One, par36, p.14.
[101] Relative, Independent Inquiry Report, Volume 1, par39, p.61.

In another (particularly strange) example of passive aggression, relatives assert that nurses removed chairs from the ward at night so that visitors could not sit in them, characterising this as deliberately obstructive in intent. Thus:

> 'I do not believe that the staff were happy about the fact that I had raised a complaint, , because they did strange things like take the visiting chair away when my daughter went to sit with him .. she had to sleep on the floor when she visited.' [102]

> 'Despite family complaints, the nurses left the door to the room open and chairs from her room were frequently borrowed.' [103]

> 'the nights were dreadful. The first three or four nights there wasn't even a chair for us to sit in. Whenever we did find one, we would go to the toilet and come back and find it gone. The nurses made it perfectly clear that they didn't want us there… made it very clear they didn't want us there at all.' [104]

These examples imply that nurses are removing the chairs so that relatives cannot stay with their family at night. If this is the case, it would indicate a high level of passive aggression, with nurses' hostility towards relatives' attendance being expressed (or achieved) through the removal of certain objects rather than by directly confronting the subject of their ire or anger.[105] Taken all together, one can see that such behaviours protect organisational agents from demands placed upon them, by reducing help-seeking or decreasing the presentation of need. This would be unconducive to altruism.

Overall, instead of seeing a pattern in which agents see users as worthy or deserving, the case is characterised by the depiction of them as unwelcome or unwanted. Effectually, user needs, especially those of patients, may be characterised as a burden. Typifying such a stance, one relative explains:

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[102] Relative, Public Inquiry, Anonymised Relative 10 Witness Statement, par17.1, p.4/5.
[103] Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.104.
[104] Relative, Public inquiry, Anonymised Relative 19 Witness Statement One, par25, p.10.
[105] By way of counterargument, relatives could be misconstruing something as simple as a lack of chairs as intentionally hostile simply because they feel unwelcome more generally.

> ‘we were a nuisance. They didn’t really want us there. The whole attitude was “Don’t bother us, we’re busy. Don’t ask anything, we haven’t got the answers”. It was looks and shrugs of the shoulders and things like this if you made a query, you know, as to my mum’s health or was anything happening or – you know any query at all.’ [106]

Notably, users perceive a situation in which staff feel negatively about them. As one says ‘you know, you’re a pain.’[107] Illuminatingly, one patient explains:

> ‘The nurses made her feel like she was a burden.’[108]

Thus, patients are seen as an encumbrance, their relatives are perceived as a nuisance and requests for help are treated as an interruption or inconvenience, that is something which agents do not have time to accommodate. In some examples, users’ presence itself is made wholly unwelcome. By way of illustration, one relative describes a nurse who says ‘we don’t like you visiting during mealtimes’.[109] The general discourse evident in examples such as these is that relatives are in the way. Irrespective of whether agents are consciously or unconsciously seeking to deter users from approaching them, the point is that they perceive themselves as unwelcome or their requests for help and assistance as unwanted. Such effects would lessen altruism by reducing the presentation of need.

The anger which agents direct towards users as a result of unwanted expectations is highly relevant. Users see it as an attitudinal deficiency. However, anger is also evident in the other direction. For example, one relative explains how, when a family member was moved into the uncleaned room of an infected prior occupant, they became very angry and called the hospital to complain.[110] Another speaks of

[106] Relative, Public Inquiry Report, Volume 3, par25.30, p.1606.
[107] Relative, Public Inquiry Report, Volume 3, par25.30, p.1606.
[108] Patient, Independent Inquiry Report, Volume 2, p.113.
[109] Relative, Independent Inquiry Report, Volume 1, par128, p.88.
[110] Relative, Public Inquiry, Anonymised Relative 15 Witness Statement, par11, p.3.

becoming angry and complaining after seeing that the records were missing for the three days before their relative's death.[111] By way of a typical example of user anger:

> 'I felt that the meeting was completely useless. [REMOVED] and [REMOVED] just tried to fudge us off with protocol and it became clear that they had only agreed to meet with us to try and justify the Trust's own version of events…I left the meeting feeling very angry….. crying with frustration.' [112]

In the first two instances, anger prompts relatives to complain. Both concern support services, that is cleanliness of a patient's room or the management of their records, rather than clinical care. Relatives would find such aspects easier to evaluate. In the third example, inadequate responses intensify a relative's anger. This typifies a pattern in the data in which: relatives are angered by events; they complain about them; they receive an unhelpful response; and their feelings are elevated by such unresponsiveness. Thus, organisational users' anger does not effect change, instead it becomes be a source of ongoing relational tension. An escalation of incivilities derives from this.

To summarise, the anger and hostility agents direct at patients escalates conflict. Users become angered by the ill-usage of in-group members. Their anger is underpinned by a level of moral other-condemnation. This prompts opposition towards agents and spurs clashes. However, it is also protective in nature. Towards fellow users, it precipitates an other-orientated reparative moral force. It stimulates users' assessment of other user group members' needs and motivates them to repair or redress perceived injustices. There is a pattern in which users notice an event in which a patient is ill-used, feel angered by that ill-use, condemn that ill-usage or the person who is responsible for it (the-ill-user) and, at times, confront or denounce them. Their condemnation or disapproval is altruistically motivated. Their confrontation or denunciation of agents is a physical expression of that.

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[111] When we saw the notes we got angry and complained. As well as some of the statements that we have previously referred to it looked like there were records missing for the three days before [REMOVED] death.' (Relative, Public Inquiry, Anonymised Relative 12 Witness Statement par36, p.9)

[112] Relative, Independent Inquiry Report, Volume 1, par23&24, p.6.

6.2 The Diminishment of Organisational Users

The climate of conflict within the hospital is also evident in the derogation or diminishment of organisational members. This is most visibly manifested in agents' disrespectful or undignified treatment of patients. The Independent Inquiry concluded that people's humanity was not always recognised in the hospital.[113] Three elements are evident in this: the treatment of users as less human entities; a more active demeaning or denigration of them and their scapegoating as problems in and of themselves (see Appendix 11: Diminishment Narratives).

Beginning with the first of these features, instances in the data show that patients may be diminished by their characterisation as nameless entities. Users provide examples in which agents do not recognise them or their individuality.[114] Typically, one relative describes how:

> 'The nurses never offered me any conversation; they never even addressed me as a person. They never spoke to [REMOVED] either. They never mentioned his name, and they certainly never mentioned mine.' [115]

Patients may be also characterised as having some reduced value or worth. By way of example, users describing their experiences at the hospital speak of how 'you are a number'.[116] Some highly illustrative examples are:

> 'their mother was not treated as an individual……none of the patients they observed were treated as though they were an individual person.' [117]

> 'When they did anything for [my father], it was never: […], I am going to do so and so; or Mr […]; or whatever. They just treated him as if he wasn't there.

[113] 'The attitude of staff could be variable, some demonstrating a commendable recognition of the humanity of those they engaged with while others did not. (Inquiry Chairman, Independent Inquiry Report, Volume 1, par205, p.109)
[114]She hated being called [REMOVED] and, although we asked on numerous occasions that she was called [REMOVED], everyone kept calling her [REMOVED]. This upset me, as Mum had limited hearing and sight. If you call someone by a name that they are not known as, they are not going to respond.' (Relative, Public Inquiry, Anonymised Relative 07 Witness Statement, par5, p.2)
[115] Relative, Public Inquiry, Anonymised Relative 11 Witness Statement, par7, p.3.
[116] Other Role, Independent Inquiry Report, Volume 1, par23, p.156.
[117] Relative, Independent Inquiry, Summary of Oral Evidence, Week 3.

> As if he was just – well, as I said, a log of wood or something like that.' [118]
>
> 'We didn't see anyone treated as an individual. We were a commodity to be shifted through the system as quickly as possible.' [119]

Critically, such examples indicate that patients are perceived as lesser. They are not individuals, but a 'number,' 'log of wood' or 'commodity'. Importantly, inanimate or unhuman objects can be treated differently. That has implications for altruistic or helping behaviour. A patient who is not an individual does not require care or concern. They can be moved through the system without reference to their welfare. Knowing that one has been (or will be) denigrated would make them less likely to seek help. Diminishing patients makes them (or their needs) less worthy of aid. So even if employees perceive patients' need for help, they can avoid appreciating it or having to assess their obligation to respond. Diminishing patients in this way allows organisational agents to avoid responding or respond in different, potentially less helpful, ways. The pattern fits with Bandura's (2002) assertion that recasting the nature of the victim can absolve one of misconduct if one fails to act prosocially.

Turning to the second feature of patient diminishment, they are, at times, more actively denigrated or demeaned. By way of example, one patient was told he was a 'dirty old man' and that he should not expect to have his sheets changed each time he soiled himself.[120] Another explains how staff made 'derogatory' comments about her partner being young enough to be her son.[121] Illuminatingly, a patient explains:

> 'There were two nurses that were actually talking about the patients, and they were laughing about them...They had just come out of the ward and were laughing and saying about the smell in there, and they were talking in general, thinking that because he had had a stroke, he wasn't able to understand that they were actually taking the mickey out of the patients.' [122]

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[118] Relative, Independent Inquiry Report, Volume 1, par27, p.157.
[119] Relative, Independent Inquiry Report, Volume 1, par294, p.133.
[120] Independent case notes review, Independent Inquiry Report, Volume 2, p.126.
[121] Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.270.
[122] Patient, independent Inquiry Report, Volume 1, par28, p.257.

In two of these examples, patients are characterised as physically unclean, dirty or smelly. In another, there is an implication of sexual impropriety or misconduct indicated by the age gap between sexual partners. All three indicate a level of disgust. An other-condemning emotion, disgust obviates the need to help by making the one needing aid unworthy of receiving it. If one can deny that a need is genuine because its recipient is unworthy one can avoid calls upon one's altruism. Demeaning those who need help also reduces the cost of inaction. One does not need to feel guilt or shame because they are undeserving. Dehumanising users in this way is unconducive to altruism.

According to Haidt (2003), disgust is plausibly prosocial since it might make us ostracise those guilty of moral infractions. It could play a similar role in safeguarding or protecting the social order when elicited by moral breaches or personal offences (Rozin, Haidt and McCauley, 2008). Here, however, the use of disgust appears more in line with Harris and Fiske's (2006) studies, in which it is used to identify an undeserving out-group, one that is perceived with lower levels of warmth. In the above examples, patients are recast as unclean, dirty or sexually deviant. This allows agents to adopt a morally disgusted stance towards them. As a result, the assessment of users might be negative, deeming them underserving, while any assessment of agents' own obligation to help them would be reduced and could even be obviated altogether.

Organisational agents' responses towards alcohol in the hospital are highly suggestive of such an effect. For example, one relative explains how, after her mother told staff about having consumed alcohol 'the doctor's attitude changed and she was not treated with the same care'.[123] In a particularly illuminating example, another relative explains how:

[123] Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.71.

> 'Her husband was unhappy with the consultant's attitude, primarily as he seemed to be convinced that his wife was suffering from alcohol-induced pancreatic disease. Her family constantly emphasised that she only consumed alcohol occasionally and never to excess, and indeed had drunk very little since her first pregnancy in 1978. The family believe that the consultant's assumption and refusal to listen …… clouded his judgement.' [124]

An alcoholic is someone who can be accorded blame for bringing about their condition. You could frame their illness as underserving of treatment because they brought it on themselves. By such means, you might deny that their need is genuine. You could also deny that there is a suitable action you could take to help them since they will continue to drink and thus undo any treatment you provide. Notably, in Piliavin et al.'s (1969) study a drunk is less likely to be helped because the cost is higher (i.e. more disgust) whilst the costs for not helping is lower (i.e. less self-censure because a drunk is responsible for his own condition). In this way, lessening patients, or making them culpable, obviates the need for altruism because they 'brought it on themselves' or may undo your treatment. Once again, in keeping with Bandura's (2002) arguments, by shifting blame onto patients, organisational agents can reduce the cost of inaction, including any self-sanctioning that would normally arise from their not acting. By reducing user worth, any assessment of the need for altruistic or helping behaviour towards them is likely to be simultaneously eroded.

Taking this one step further, users may be re-framed as the problem in and of themselves. This is the third element visible in the diminishment of patients. This time the problem is not patients' sickness or symptoms. Nor is it their pain and suffering. Neither is it any ill-usage to which they have been subjected by agents. Instead, the patient, or their family, are the problem. The Independent Inquiry, for example, concluded that patients who suffered from states of acute confusion were treated as if they were behaving badly, rather than being unwell.[125] Typical examples of patients being treated as inherently problematic are:

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[124] Relative, Independent Inquiry Report, Volume 1, p.148.
[125] Inquiry Chairman, Independent Inquiry Report, Volume 1, par21, p.401.

> 'I said why – you have rushed the blood through… and she said – she said – no, she said, what has happened is I have had to come in and give the blood and don't moan, she said, because I have had no break today.' [126]

> 'Following her husband's death his wife was spoken to by a nurse in the pub who said "her husband was disgusting to get so fat, he needed every porter in the hospital to move him".' [127]

In one of these, asking a question is reframed as having unreasonable expectations of staff in the light of other demands upon the particular employee concerned. In the other, a patient's physical condition (as opposed to actual illness), and the difficulties that causes these employees in handling him, is the problem. His weight is a reason not to appreciate his situation. The emotional costs of not helping him are reduced because one does not have to feel sympathy or compassion for him as a less worthy human being. By way of a particularly illuminating example in which agents blame users, a patient explains how:

> 'The same nurse who was previously reprimanded for her unacceptable behaviour came back into my room. She said "you've made me ill! I have been off sick with stress because you reported me".' [128]

In this instance, the employee is arguably projecting their sickness onto the relative, indicating that it was caused by their complaint. Blaming or problematising users in these ways makes them less worthy of help. Such patterns align with Faust's (2009) claims that healthcare professionals can absolve themselves of compassion by deeming patients as undeserving.

A significant effect associated with the dehumanisation or diminishment of patients is other users' moral responses. Righteous, moral or empathic anger derives from a perception that there has been a violation or breach of moral standards towards oneself or others (Tangney et al., 2007). Empathic anger arises from seeing someone

[126] Relative, Independent Inquiry Report, Volume 1, par6, p.153.
[127] External Organisation, Independent Inquiry Report, Volume 2, p.106.
[128] Patient, Public Inquiry, Anonymised Patient 01 Witness Statement, par11, p.4.

else being unjustly or unfairly treated and has the capacity to turn your empathic distress into a sense of injustice, angering you at those who ill-use others and motivating you to address their ill-usage (Hoffman, 2008). There is a clear pattern of such moral responding in the data. Firstly, users express distress about other users' situations. Secondly, they articulate a sense of injustice. They judge the situation as wanting. For example, they say: 'I was outraged' and 'I was absolutely stunned'. Their anger is provoked by behaviour they disapprove of and consider unjust or unfair. There is a sense of condemnation, either of the ill-user, the ill-usage, or both of these. Thirdly, there is evidence of action which is associated with their anger, such as complaining. So, user group members' moral or righteous anger is also associated with some specific reparative actions that indicate altruism towards patients.

Such actions may be active or passive and directly or indirectly aimed at helping the patient or punishing organisational agents who mistreat them. One action commonly associated with morally-infused ire or anger is users' condemnation of organisational agents. That condemnation may be undertaken mentally or verbally and carried out in public or private. Another associated action is confronting organisational agents about their actions, emotions or behaviours, complaining to (or about) them within the hospital or raising the matter of their perceived misconduct with another source. Importantly, one also sees reparative action targeted at addressing perceived injustices. So, the mistreatment of its users by an organisation provokes altruistic or helping behaviour on their behalf. For example:

> 'she said to my Mum:… what medication have you had today? Is Mum supposed to remember that?... and my Mum had said: sorry, what did you say? And she snapped: I said, what medication did you have? I said: excuse me, I didn't understand what you said, you'd mumbled it.' [129]

> 'I went later to find this lady and said: excuse me, don't treat my Mum like an elderly idiot. She is a 67-year-old lady who is fighting for her life. All she wants to do is get mobile and go home and be with her family.' [130]

[129] Relative, Independent Inquiry report, Volume 1, par295, p.134.
[130] Relative, Independent Inquiry report, Volume 1, par295, p.134.

> 'Unfortunately the room he moved into was not cleaned after the previous person had moved out. The previous person had also suffered from C. difficile. I was very angry at this and called the Trust to complain about the condition of the room and was told that the room would be cleaned the next morning. My sister and I stayed at the hospital all that morning and no one came to clean it. In the end we bleached the entire room ourselves.' [131]

In the first two examples, one sees a relative confronting agents about the inappropriateness of their behaviour. In the third, one sees relatives attempting to redress the poor treatment of a family member, placed in a dirty, potentially infectious room. Firstly, they seek to address this by complaining to staff. Secondly, when that fails to redress the situation, they clean the room themselves. Such examples suggest that the anger which users express or exhibit is moral and empathic in nature. It prompts feeling as well as judgement. The observers are clearly emotionally stimulated by, and concerned about, the treatment of patients as people with human frailties, as well as their treatment as patients with clinical needs. Importantly, this appears to precipitate reparative or correction action. That action also has a cost, such as having to confront people, which may be uncomfortable, or going and tracking people down to obtain help, which may take time. This is not confined between family members. Importantly, there is a clear and strong altruistic in-group effect operating between users as a whole. However, this pattern contrasts sharply with that of organisational agents.

[131] Relative, Public Inquiry, Anonymised Relative 15 Witness Statement, par11, p.3.

6.3 Conflict Climate Conclusion

The hospital is characterised by extensive internal conflict. User group members are angered by the perception: that patients (both related and unrelated) are being poorly treated; that their care is physically, clinically or attitudinally deficient; or that employees' actions, emotions or behaviours do not meet expected norms or standards concerning the caring process. Agents are angered by apparently unwanted, unmeetable or unwarranted expectations others are perceived to be placing upon them. Their anger is directed at users, as well as at the organisation and its agents, including peers, managers, leaders and so on. The differing triggers are summarised below (see Table 5).

Table 5: Sources of Organisational Member Conflict

	SOURCE	DESCRIPTION
1	**TREATMENT DEFICIENCY**	Conflict caused by perceived fallings in clinical (or other) forms of treatment, such as basic care.
2	**ATTITUDINAL DEFICIENCY**	Conflict caused by someone's perceived attitudinal failing (and/or related behaviours).
3	**UNMET EXPECTATIONS**	Conflict caused by expectations you have of someone which they have failed to meet.
4	**UNWANTED EXPECTATIONS**	Conflict arising from expectations placed upon you which you feel you cannot or should not have to meet.

The result of all these tensions is an organisational context that is characterised by a climate of conflict and poor quality member relationships. The two groups respond to this in different ways. Where agents are concerned, conflict undermines their responsiveness towards out-group members. Importantly, agents are angered on their own behalf as the subject of perceived ill-use. Their ire or frustration is directed at those whose demands are conceived of as unreasonable in some way and thus a form of ill-usage. A self-orientated, defensive personal force appears to arise out of this, a force aimed at protecting staff from unwelcome demands. A significant part of this is their diminishment of patients. This is likely to inhibit altruism by means of its influence on their assessment of need. Psychologically lessening users, for

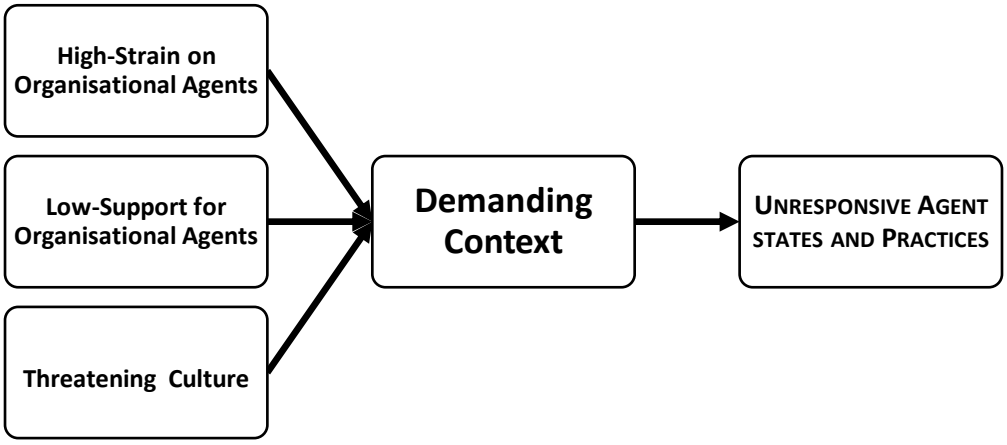
example, means that even if their needs are ‘seen’, they do not necessarily have to be ‘felt’ or ‘judged’ worthy. This would make altruistic action less necessary or likely.

By way of contrast, where users are concerned, conflict leads to a kind of promotive morality. Users are angered by perceived failures to help them in line with expected norms and standards of care. Unmet expectations stimulate anger on their behalf which is moral, empathic or righteous in form. It has the power to prompt action which is reparative, that is providing redress for someone who has been ill-used. It also prompts more punitive actions, punishing those who perpetrated the ill-usage. Effectually, user group members notice in-group members’ mistreatment, perceive it as significant or important, appreciate the distress it causes them, undertake an assessment of such treatment and judge it as wanting or worthy of redress. Such factors can promote altruistic or helping behaviour, by motivating in-group concerns for other patients.

7 CHAPTER 7: A DEMANDING ORGANISATIONAL CONTEXT

Another final prominent narrative to emerge from this case is the hospital's demanding internal context. In this case, the organisational terrain is characterised by a high strain on agents to meet internal demand coupled with low levels of support or resource with which to meet it (see Figure 13). These factors add to the pressure on organisational agents which already arises from their working with highly distressed and distressing organisational users (see Chapter 5) as well as the climate of relational tension and conflict within which that work must be done (see Chapter 6).

Figure 13: Demanding Context in the Hospital



This context is also characterised by a threatening culture which diminishes the cultural, social or relational support for organisational agents from their managers, peers or supervisors inside the hospital.

7.1 High Organisational Strain

As an organisation, the hospital places significant demand upon its staff. The internal operational context is characterised by extensive pressure to meet the day-to-day

demands of one's role, operate within set routines and meet managerial or organisational goals, as well as any targets and deadlines which govern how those should be met. If it was only generalised statements about the pressures generated by the hospital's context, one might conclude that this narrative is a form of self-justification, evidence of a post-hoc defence, articulated this way in the light of inquiry witnesses' hindsight. However, there are many specific or detailed examples of such pressures in the data. Moreover, such issues were raised by staff before the inquiries. The 2007 NHS staff survey concluded that only 17 percent of hospital employees felt that there were enough staff to do the job properly, whilst 52 percent felt they did not have enough time to carry out their work.[132] Convincingly, users perceive the same pressures.

The high level of demand in the hospital is evident is intensive working patterns. These are characterised by long hours, double or back-to-back shifts and late nights. It can also be seen in staff taking work home. By way of example, one nurse describes being up until 1.00 am working on a report, despite having 7.00 am shift.[133] Another explains that nurses, as a group, were often forced to work long hours and then take their paperwork home with them because there was not sufficient time to complete it when they were at the hospital.[134] The breadth and depth of physical demand which employees must meet in the time available, both in terms of the quality and quantity of their work, generates an exacting pace. One nurse describes an 'average shift' as 'pressure, pressure, pressure'.[135] The intensity of all this is articulated in an anonymous letter staff sent to management stating:

> 'unmanageable workloads, going without breaks, not getting off on time, doing extras with no respite.' [136]

[132] Public Inquiry Report, Volume 1, par2.367, p.234.
[133] Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par19, p.6.
[134] Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par72, p.20.
[135] Nurse, HealthCare Commission Report, 2009, p.49.
[136] Anonymous Letter, Independent Inquiry Report Volume 1, par78, p.205.

Such intensity will have consequences for organisational agents' capacity to respond to patient need. There are significant costs to such practices which undermine organisational agents' responsiveness. These costs make altruistic or helping behaviour less likely.

Notably, this way of working places a high mental, physical, temporal or emotional strain on organisational agents as a group. By way of an example, one nurse describes how their feeling 'upset,' 'worried' and 'stressed' resulted in asthmatic attacks and weight gain.[137] Along similar lines, a doctor explains that undertaking ward rounds gave them palpitations due to the pressures associated with these.[138] Organisational agents also exhibit symptoms of fatigue and depletion. In their anonymous letter to managers, staff state that:

> 'We all [sic] exhausted, mentally and physically. ……The environment is neither safe for patients or staff.' [139]

Patients also perceive this effect. By way of example, one patient explains that

> 'there were not enough staff and the nurses were clearly exhausted.' [140]

Such conditions would strain the collective capacity of organisational agents as a group. It would deplete their mental, physical or emotional energy with which to help users and squeeze the time available within which to do so. Such scarcity would reduce internal capacity to perceive organisational users' needs or appreciate and enter into them. It could also negatively impact on the likelihood that user needs are being actively monitored or fulsomely assessed. Such conditions would be unconducive to altruistic or helping behaviour and are therefore likely to lessen it. However, they are also unconducive to good care.

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[137] Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par67, p.18.
[138] Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par43, p.10.
[139] Anonymous Letter, Independent Inquiry Report Volume 1, par78, p.205.
[140] Patient, Independent Inquiry Report, Volume 2, p.70.

Time constraint is one of the most visible manifestations of organisational strain on agent helping capacity. Time constraint is referenced by almost all types of witness who provide statements to the Inquiries. An expert report on the case confirmed that hospital staff did not have time to perform their work well and were 'rushed off their feet' (Alberti 2009, p.13). The temporal strain of acting, and any related costs, are clearly very keenly felt by hospital agents as a group. Many refer to time limitations of one sort or another (see Appendix 12: High-Strain Narrative). Typically, one doctor states:

> 'We were all working crazy hours, perhaps 70 to 80 hours per week and we were on call on top of this.' [141]

Another talks of how nurses felt the pressure of caring for patients in a given timeframe.[142] Managers share this perspective. One says 'There were not enough hours in the day'.[143] Another explains that 'People were busy running around, doing three things at once and not taking breaks, or lunch'.[144] The point is that this context requires one to work without self-determination or respite.

Organisational agents are not the only group who describe this pattern. Organisational users also depict staff at the hospital as having insufficient time within which to carry out their work. By way of some typical examples, users say:

> 'I was concerned that there was a lack of staff to provide adequate care and found that nurses often worked double shifts.' [145]

> 'They didn't really have time. There were not enough around.' [146]

> 'I waited for four and half hours while one extremely harassed doctor raced around like a headless chicken.' [147]

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[141] Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par67, p.21.
[142] Doctor, Public Inquiry, Anonymised Employee 21 Witness Statement, par66, p.15.
[143] Senior Executive, Public Inquiry, Anonymised Employee 06 Witness Statement, par43, p.12.
[144] Manager, Public Inquiry, Anonymised Employee 09 Witness Statement, par5, p.2.
[145] Relative, Independent Inquiry Report, Volume 2, p.236.
[146] Patient, Public Inquiry, Patient A Witness Statement, p.101.
[147] Patient, Public Inquiry, Anonymised Patient 02 Witness Statement par3, p.2.

> 'There were also very few nursing staff on the ward and they came across as overworked.' [148]

The presence of many examples like these in the data indicates that users also believe that the hospital is a temporally pressured organisation, characterised by high levels of demand, which places a high strain on agents.

Importantly, too little time is unconducive to altruism.[149] In this case it appears that being hurried can take precedence over users' welfare needs. Organisational agents appear, or claim to be, 'too busy' to help when asked. They rush around, walk quickly, hurry past users and so on (see Appendix 12: High-Strain Narrative). The state of being or feeling 'too hurried' has the power to lessen their ability to 'see' patients' needs. This consequently reduces the likelihood of agents developing any 'feelings' for patients as a result of their situation or making any judgements about the need to act. Hurrying through situations lessens agents' exposure to the emotional noise present in this environment. It reduces their interaction with users with whom they may be in conflict. The latter is especially pertinent where patients are perceived as demanding. Critically, it enables organisational agents to pay them less attention and thereby avoid seeing their cues that help is needed or having to experience the emotional tenor of such signals. That, in turn, removes the need for agents to assess patients' needs or condition.[150] In this way, organisationally induced pressures could reduce altruistic or helping behaviour by initially lessening agents' perception of users' needs, subsequently lessening the chances that users' needs are appreciated and finally obviating any need for assessment of those needs.

Certain cognitive and affective states are associated with this demanding context. High-strain conditions appear to generate inward focussing mental or emotional

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[148] Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.119.
[149] Being hurried is shown to reduce altruistic or helping behaviour (Darley and Batson, 1973).
[150] It would also preclude employees' from developing the knowledge and understanding of patients which is conducive to good care. Emotional labour with patients, for example, requires time and demands substantial knowledge of the patient as a person (James, 1992). However, reduced understanding of patients themselves impair employees' ability to judge whether their needs are genuine and require a response.

states which direct organisational agents' attention away from patients. Starting with the cognitive effects of working in such as context, the terminology used to describe agents' state indicates significant mental strain. For example, doctors say:

> 'I was working under pressures that would have broken most people.' [151]
>
> 'you work a team that hard for so long you begin to break people.' [152]

Language such as 'break' or 'broken' indicates the presence of considerable cognitive strain. Such strain would deplete staff of the mental resources they might draw upon to quickly identify patients' needs and speedily determine suitable responses. As a group, their mental band-width with which to assess organisational users' distress would thus be weakened or contracted.

Alongside evidence of a mental strain upon organisational agents associated with the demanding internal context is evidence of an accompanying emotional strain. Hospital staff are clearly an anxious group. By way of one illuminating example, a relative describes the effect of time on a hospital porter's mental state:

> 'The porter told me that he was struggling to find an oxygen cylinder that actually contained some oxygen as they were all empty. The porter was quite anxious and he told me that he had a 15 minute slot in which to move mum or he would be in trouble.' [153]

This example shows an underlying sense that services are measured in units of time (as opposed to care). Significant anxiety is clearly attached to this. Such inwardly orientating moods or emotions direct employee attention to their own state. In this way, demand might reduce agent attention to user needs and stimulate inattentive practices. However this context is not merely an anxious one for employees, it is also fearful. As one nurse explains:

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[151] Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par14, p.4.
[152] Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par88, p.26.
[153] Relative, Public Inquiry, Anonymised Relative 19 Witness Statement One, par18, p.8.

> ‘Many of the new recruits had no experience and were terrified at the level of work they were asked to do.’ [154]

The Healthcare Commission (2009) said staff believed that they were ‘in the firing line’ if they did not meet organisational goals or targets and consequently liable to blame. Clearly, the requirement to meet hospital demand, together with the prospect of repercussions for failing to do so, is a destabilising cultural force, generating negative emotions in the face of such threats. At times, hospital staff become overwhelmed. For example:

> ‘He found one nurse crying as she had worked for 12 hours without a break and at the weekend.’ [155]

> ‘The nurses were overwhelmed with the number of patients, one crying with exhaustion and frustration.’ [156]

Working in an intense environment such as this would drain organisational agents of affective resource. As a group, their emotional band-width, that is their resources to appreciate others’ distress, would also be weakened or contracted. Critically, they may lack the rich capacity to feel with (or for) others which is able to stimulate altruism. The absence of such richness would also undermine the potential for compassionate patient care.

Another evident feature of high strain within the hospital is the conflict which organisational agents experience about which elements of their roles to prioritise in the light of organisational expectation. Their descriptions indicate that trying, or being expected, to meet the responsibilities attached to one’s formal organisational role and deliver the requirements of tasks and routines associated with it, places a significant pressure upon them. The Healthcare Commission, for example, speaks of how: ‘junior doctors were put under pressure to make decisions quickly without

[154] Nurse, Independent Inquiry, Anonymised Employee 23 Witness Statement Number, par3, p.2.
[155] External Organisation, Independent Inquiry Report, Volume 2, p.135.
[156] Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.45.

advice and support from more senior doctors.'[157] These organisational constraints, and the pressures associated with them, force agents to make unpalatable choices or compromises regarding what they do for patients. In one illuminating example, a doctor says:

> 'People were trying to satisfy pressures on them and minimise the hard time which they were given by managers and this became the sole priority.' [158]

Picking up on the previous point about depleted cognitive and affective resource, such conflict also generates emotional discomfort and mental discomposure amongst organisational agents as they strain to decide which aspects of their roles to deliver. By way of some typical examples:

> '…nurses felt very uncomfortable. They felt outside their comfort zone. They felt that they were not very happy, there was a lot of unhappiness and [sic] felt that they were not doing the best to their patients.' [159]

> 'I would go home in tears because people were being treated so badly in that Hospital and were suffering so unnecessarily.' [160]

Clearly, demand limits organisational agents' autonomy. It forces them to make choices about which aspects of their work they perform, restricts the time they can spend responding to patients' welfare needs and limits their ability to undertake any additional voluntary or discretionary effort where that is concerned. As well as being acknowledged by internal witnesses, such constraint is also perceived by external witnesses.[161] Importantly, it would be unconducive to altruism.

Finally, this demanding organisational environment also appears detrimental to organisational agents' sense of personal efficacy. In the hospital one sees examples of them expressing, exhibiting or articulating a resigned stance that raising their

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[157] Healthcare Commission Report, 2009, p.7.
[158] Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par12.
[159] Doctor, Independent Inquiry Report, Volume 1, par74, p.204.
[160] Nurse, Public Inquiry, Witness Statement Anonymised Employee 23, par9, p.4.
[161] External Individual, Public Inquiry, Anonymised External 96 (GP) Witness Statement, par10, p.3.

concerns will not have an impact. Those reporting to the Healthcare Commission (2009) express a lack of confidence that doing so would effect change. Incident reporting, in particular is described as a 'black hole' and a 'waste of time'. There is a clear assumption that raising issues and concerns will not change the situation. As illustrated below:

> 'if clinicians took problems to the hospital management the criticism would fall straight back to them. I remember ringing one consultant and he told me that if I copied in the chief executive to my letters, the chief executive would simply hand the letter straight back to him and nothing would change.' [162]

Arguably, such cynicism is fuelled by denying that your actions are, or will be, effective.[163] It is also a potential means of escaping a situation. It may be a method by which one can cognitively reframe or reappraise it. To illustrate this point, if one sees the organisation (or its agents) acting improperly or making mistakes, then one is arguably obligated point this out to them. If one can say to oneself that this will not rectify the mistakes or prevent further impropriety from occurring then complaining about it becomes an action of no value. Thus, one can deny that there is a suitable action which one can carry out. This would make speaking up, or speaking out about matters, an action which would be high on cost because of the social penalties involved, but low on reward or benefit because it changes nothing. Feasibly, a culture characterised by such a mood would be unlikely to create conditions conducive to altruism. Agents may come to feel inefficacious about their ability to take effective action in order to meet patients' needs. This may not be so much in relation to patients' needs individually, but rather collectively. Thus, they may feel unable to meet patients' needs as a group. Moreover, the altruism required for rule-breaking or whistleblowing on their collective behalf might be deterred by such conditions.

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[162] External Individual, Public Inquiry Report, Volume 1, par 2.144, p.178.

[163] However, while resignedly saying that complaining will not change anything is a reason not to raise any concerns, it is also a means of justifying not doing so.

7.2 Low Organisational Support

Alongside the depiction of the hospital as a site of high organisational strain, there is its presentation of it as a site of low organisational support. It an environment in which staff can see themselves as poorly resourced to meet demands. A lack of sufficient resources with which to deliver the physical aspects of the job within the expected timeframe to the expected level of quality is a prominent narrative (see Appendix 13: Low Support Narrative). Constrained or limited resources referred to in this case include: peers, who are perceived as too few in number (or lacking in skill); equipment, which may be faulty, outdated or scarce; facilities, which includes antiquated buildings and unhelpful ward configurations; and finances, which may be the underlying cause of all these. Thus, alongside organisational agents' reduced personal resources discussed in the previous section, is a lack of organisational resources which might erode their efficacy or capacity further.

In this case, insufficient staffing with which to deliver the work emerges as one of the most important internal organisational resource constraints. This includes staffing numbers, skills mix, seniority or experience and availability. Agents clearly see themselves as under-resourced to carry out their roles or meet their responsibilities. They talk of staff groupings as being 'denied the basic tools they need to do their job properly,' and describe teams or departments as 'hideously under-resourced,' 'understaffed,' 'under resourced' and 'horrendous.' [164] [165] [166] There are many examples of organisational agents, both managerial and professional staff, indicating that there are insufficient numbers of staff. They say:

> 'there were simply not enough people to provide basic care.' [167]
>
> 'I saw lots of examples of simply not enough nursing care.' [168]

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[164] Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par40, p.10.
[165] Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par47, p.14.
[166] Manager, Public Inquiry Report, Volume 1 , par2.341, p.277.
[167] Senior Executive, Public Inquiry, Anonymised Employee 02 Witness Statement, par78.
[168] Doctor, Public inquiry, Anonymised Employee 18 Witness statement, par35, p.100.

Importantly, these claims are backed up by statements from hospital users. They also perceive an inadequate number of employees. Notably, awareness of the problem extends beyond the hospital bounds into the local healthcare environment. By way of example:

> 'there was certainly great and increasing disquiet regarding the pressure of work on nurses following staffing cuts at the Hospital….It was clear that there was increasing disquiet .. regarding inadequate levels of staffing.'[169]

Insufficient or inadequate human resource is particularly perceived to be associated with unresponsive patient care. In this regard, factors which are unconducive to altruism would also be unconducive to good care.

Resource constraint is also evident amongst staff employed within the managerial hierarchy. Organisational agents working in management roles are also affected by resource pressures, albeit of a different kind and from a different source. Financial constraints are imposed upon them internally by hospital leadership, as well as exercised over them by external agencies. Commenting upon such matters, doctors say:

> 'I believe this requirement to cut the budget would have come right from the top.' [170]

> 'In my view [REMOVED] had his hands tied. He had to balance the books; he had to get FT status and he had to sort the problems out at the Trust notwithstanding that money had been taken out.' [171]

These instances Illustrate the role of leadership in imposing such constraints, as well as the role external factors play in creating the need for them. Pertinently, managers are not exempt from inadequate resource with which to meet organisational demand. Though the source is different, they experience similar constraint. This

[169] External Individual, Public Inquiry, Anonymised External 96 (Witness Statement, par10, p.3.
[170] Doctor, Public Inquiry, Anonymised Employee 19 Witness Statement, par14, p.5
[171] Doctor, Public Inquiry, Anonymised Employee 19 Witness Statement, par15, p.5.

struggle could absorb their attention, have the power to direct it inwardly and potentially reduce their appreciation of employees' predicaments as a result. In this regard, the potential impact of context on their capacity for altruism towards staff would mirror the impact of context on employees' potential for altruism towards patients.

Alongside a lack of physical resources with which to meet workplace demands, there is a lack of cultural or relational support for those delivering them which might assuage the strain they feel. The organisational context is one in which contact between agents is infused with conflict. Their relationships are strained, tension between them is high and conflict is continuously present. There is evidence of fractious day-to-day interaction amongst organisational agents. There are ascriptions of 'clear clashes of ethos, ego, and basic philosophy' between peers.[172] There was tension within or between different tiers or professional groups. There were, for example, claims of 'factions' within the management team.[173] Similarly, interpersonal relationships between certain professional groups was seen to be 'poor'.[174] More junior groups of staff were described as 'intimidated'.[175] Conflict infused both formal and informal terrains. Meetings were described as unpleasant.[176] They could even become hostile and aggressive. By way of example, one doctor describes a colleague who was supposed to be at the top table in a meeting sitting instead at the back and 'haranguing' those who were.[177] Instances such as these indicate that there is friction between members of certain teams, that different groups of organisational agents are at odds with each other, that relationships are generally weakened and impoverished and that interaction can even, at times, be actively hostile and aggressive.

[172] Doctor, Public inquiry, Anonymised Employee 15, Witness Statement, par6, p.2.
[173] Senior Executive, Public Inquiry, Anonymised Employee 06 Witness Statement, p.15
[174] Doctor, Public Inquiry, Anonymised Employee 22, Witness Statement, par84, p.24.
[175] External Organisation, Public Inquiry Report, Volume 2, par18.173, p.1243.
[176] Doctor, Public Inquiry, Anonymised Employee 22, Witness Statement, par84, p.24.
[177] Doctor, Public inquiry, Anonymised Employee 15, Witness Statement, par29, p.9.

The literature indicates that support from organisations (or their leaders) can promote altruistic action. In their meta-analytic review, for example, Organ and Ryan (1995) found that altruism correlated with leader supportiveness. However, the hospital environment is characterised by low levels of relational support for staff from leaders and managers. At the time, the provision of relational support would have been challenged by the internal context. At various points within the timeline studied, the hospital was undergoing organisational restructuring, staff reductions and turnover. Frequent changes in management led to a lack of leadership or support for employees.[178] There was inadequate clinical supervision for medics and nurses, with junior doctors not adequately overseen due to shortages of senior and middle grade consultants (Healthcare Commission, 2009). Lack of certain management or supervisory tiers particularly left nurses unsupported and exposed to demands which they could not meet or manage.[179] Although there are instances of supportiveness at the hospital, unsupportiveness is far more strongly manifested in the data. References to leadership supportiveness are more likely to be negative than positive, whilst those to organisational supportiveness are substantially more likely to be negative.[180]

Organisational agents, as a group, articulate the sense that support from the organisation (or its leaders) is lacking. Rather than being a supportive mechanism, the organisational hierarchy inside the hospital, and formal management or supervisory relationships within it, are characterised as a depleting organisational force, rather than a sustaining one. The relationship between management and employees is particularly strained. Employees cite management expectations, the pressures they bring to bear upon staff to meet targets and the implicit (or explicit) threats they make regarding any failure to do so, as sources of difficult interaction.

[178] Independent Inquiry Report, Volume 1 (2010).
[179] Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement.
[180] References to leadership supportiveness are around twice as likely to be negative as positive, whereas references to organisational supportiveness are nearly six times as likely to be positive as negative.

As a consequence, contact between these groups can be hostile or aggressive. Some typical descriptions of relations with management are:

> 'an endemic atmosphere of aggression in meetings with the [REMOVED]. I think that a lot of the tension focused around money. Whenever we talked about money the conversation became hostile.' [181]

> 'She didn't like to be criticised at all. If something was happening that she didn't approve of, didn't like, then your life was made hell.....the nursing staff who came to talk to me about their problems they had got with her were saying: I can't do any more because if I do she will just make my life hell.' [182]

The first example indicates a general atmosphere of conflict, whereas the second, which concerns a particular manager, indicates day-to-day conflict within internal supervisory structures. Such examples indicate the intensity of relational difficulties.

More broadly, the hospital, as an organisation, is characterised by an unresponsive culture which underpins the unsupportiveness of its management hierarchy and the poverty of its internal employee relations. This is characterised by: staff concerns about being unheard and unacknowledged; the more active suppression of their voices, views, concerns or opinions; bullying or harassment of them; as well as associated sanctioning of any behaviour which is deemed inappropriate or out of alignment with organisational norms and expectations (see Appendix 13: Low Support Narrative).

Starting with the first of these four cultural features, there is discourse which characterises the organisation, and its leaders or managers, as discounting staff members' views or opinions. By way of some typical examples, managers and executives explain that:

> 'the medical staff felt that they didn't have a voice. I think they felt they were

[181] Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par41, p.12.
[182] Senior Executive, Independent Inquiry Report, Volume 1, par39, p.160.

not listened to so therefore there was no point speaking up.'[183]

'I was upset, and my staff were upset but unfortunately I as their manager was unable to assist them as members of the Executive team were not listening to anything I was saying.' [184]

A contemporary culture audit showed that the majority of staff did not feel listened to.[185] Amongst clinicians there was a view: that the hospital did not respond to problems they raised; that when changes were planned their views were not considered; that risks and concerns they raised were ignored; that criticism was not welcome; and that they were marginalized or even steamrollered into accepting changes that they disagreed with (Healthcare Commission, 2009). This problem is also seen to operate at board level. A new director seeking to make changes is described as 'faced with an unwilling board,' 'swimming against the tide' and 'telling the board what they didn't want to hear'.[186]

Extending the point about steamrollering, a second feature of the internal culture is a more general sense of suppression. This is an environment in which employees consider themselves as more repressed or disempowered by management. By way of example, one doctor states:

'there appeared to be a general lack of engagement between the management and the senior clinicians due to the fact that the clinicians were feeling disenfranchised.' [187]

The use of 'disenfranchised' is telling. On the one hand management might not be listening, but on the other hand they might be listening but not agreeing. Effectually, the hierarchical structures delineating relationships between management and employees may be the site of a power struggle. Such a struggle can be seen in the perception of a fixed internal view or 'party-line' to which managers are supposed

[183] Senior Executive, Public Inquiry, Anonymised Employee 02 Witness Statement, p.67.
[184] Senior Executive, Public Inquiry, Anonymised Employee 13 Witness Statement, par67, p.18.
[185] Senior Executive Public Inquiry, Anonymised Employee 12 Witness Statement.
[186] Senior Executive, Public Inquiry, Anonymised Employee 02 Witness Statement.
[187] Doctor, Public Inquiry, Anonymised Employee 17 Witness Statement, par11, p.4.

to adhere. Staff describe or characterise managers as expecting employee representatives to adopt the same fixed internal view. For example they say:

> 'Consultants who were involved in management would have nothing to do with the dissent.' [188]

> 'I was surprised that the [REMOVED] wasn't more supportive to us but she towed the party line.' [189]

Instances such as these in the data show staff characterising themselves as being expected to: follow a party line; back up the hospital management accordingly; accept matters without criticism, complaint, or disagreement; and be positive about changes irrespective of their opinions. This means that if they felt conditions were unconducive to helping, they would be discouraged from expressing that.

Moving on to a third feature of the organisational culture and its hierarchies, in this case one sees even more aggressive treatment of employees, such as bullying or blaming. The sense that agents feel threatened by the organisation's culture emerges in explorations of emotional noise (see 5.2). It is not unusual for them to depict leaders as villains in some way, describing them as: speaking of staff in a derogatory manner; bullying or harassing employees; and sanctioning or labelling anyone who disagrees with them. A culture audit (at the hospital) indicated that 30 percent of its employees had seen or experienced bullying or harassment from colleagues or managers and 85 percent of staff in the hospital perceived a blame culture.[190] Typically, staff say:

> 'There was a culture of bullying and harassment towards staff.' [191]

> 'There was a blame-led culture, the attitude being that problems had to be fixed or nursing jobs would be lost.' [192]

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[188] Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par3, p.2.
[189] Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par46, p.12.
[190] Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement.
[191] Doctor, Public Inquiry Report, Volume 1, par1.241, p120.
[192] Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par9, p.3.

> '..their response was extremely aggressive, basically telling me that they were in charge and accusing me, and anyone else who agreed with me, of not being team players.' [193]

> '…all of the staff were scared of the [REMOVED] and afraid to speak out …..in case they incurred the wrath of the [REMOVED]' [194]

Bullying can be a dysfunctional consequence of performance measurement (Mannion and Braithwaite, 2012). It is widespread in the NHS (Hands, 2013). It generates insecure emotional states, such as a sense of vulnerability or feeling of exposure (Burnes and Pope, 2007). As shown in this section, such states are evident amongst organisational agents in this case. In keeping with the latter study, employees, as a group, are depicted as feeling insecure, distressed and powerless. The presence of bullying, alongside their fears of retaliation, provides clear evidence of a threatening culture within the organisation.[195] Importantly, it is linked to staff not delivering organisational demands or meeting managerial expectations. Critically, in respect of the relational tension evident in this case, failing to meet internal norms or deliver expected goals can lead to costly repercussions.

This point leads on to a fourth, related feature of the cultural or relational unsupportiveness evident in this case. This is sanctioning, that is social punishments for failing to uphold or deliver management expectations. Failing to meet these, or expressing any dissent concerning them, can provoke costly social penalties. These include being excluded in some way by one's peers, for example being ignored or ostracised, as well as being reproached or condemned by them. By way of some typical examples:

> 'I had the impression that the [REMOVED] did not like me objecting to things

[193] Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par13, p.5.
[194] Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par8, p.3.
[195] There are a few examples of agents in this case who query this state of affairs. For example, one senior executive says: 'I never saw any evidence of this during my time at the Trust' (Senior Executive, Public Inquiry, Employee 07 Witness Statement, par173, p.45). However, there is sufficient evidence to indicate such pressures were evident in the internal context.

and that they found me a nuisance.' [196]'

'though I raised concerns revealed by incident reports at JNCC meetings and these issues were raised at surgical directorate meetings, there was a general perception by the Executive team that the nursing staff were moaning.' [197]

The point is that those who reject internal organisational norms can end up being labelled as awkward or difficult. A strong sense of threat can be attached to this. Employee reports instances of managers advising staff to be 'careful' about what they say, since 'moaning' will not help them keep their jobs and making formal complaints could actually lead to their losing them. Typically, a nurse explains that the 'culture' was that staff should be 'careful about what they say'. She goes on to explain how one manager would frequently say that if staff valued their jobs then they should stop moaning.[198] In one illuminating instance, a nurse says:

'when nurses raised issues about staffing levels not being safe [REMOVED] put pressure on them to not raise their complaints formally… she would advise staff that if they considered staffing levels were unsafe that this was a breach of the NMC Code of Conduct for the nursing profession, and they should be very careful about what they put in a formal complaint as it might lead to them losing their job.' [199]

Examples such as these underscore the potential for costly penalties. Some imply that making formal complaints might precipitate negative personal consequences through formal means. Others imply that they might generate negative personal consequences through much more informal means.

The process of labelling those who ask questions, challenge accepted norms or query practices illustrates the latter effect. Labelling is evident in tacit implications that those who raise issues are moaners and whingers. For example:

[196] Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par15, p.5.
[197] Senior Executive, Anonymised Employee 13 Witness Statement, par58, p.16.
[198] Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par72, p.20.
[199] Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par59, p.16.

> 'I myself was made to feel, by senior management, that I was whinging and that my views as a senior nurse were not to be respected.' [200]

> 'at the first Annual General Meeting for the [REMOVED], the Chair at the time, [REMOVED], stood upright at the beginning and said "We'll have no whinging or whining about the Hospital".' [201]

There is an important implication in the use of these expressions. Behind such pejorative words is the implication that there is no substance to the criticisms being expressed. Moaners and whingers are people who complain (unjustifiably) about nothing or very little. The classification suggests that they have nothing of importance to say. Evidently, this discourse provides a useful defence mechanism for managers. It is a means of denying that a problem exists or is genuine. Labelling diminishes the people who complain, lessening them as individuals, and thereby infers that their complaints are not genuine. Thus, one can deny that there is a problem which requires a response. Diminishing those who complain in this way should also actively deter them from complaining. Thus, the structural hierarchy is infused with an unsupportive and suppressive discourse which deters employees, as a group, from challenging managers, as a group. This means that employees could not easily challenge the organisational conditions which they believe are unconducive to patient welfare. However, doing so in the face of such potentially costly penalties would be altruistic.

The four features explored above, that is disregarding employees' voices, suppressing their views, and bullying or sanctioning them, indicate a high level of conflict between employees, an unsupportive organisational hierarchy and a threatening internal organisational culture. There is a clear discourse of repercussions and retaliation underpinning all of these features (see Appendix 13: Low Support Narrative). That discourse reveals that organisational agents perceive both real and imagined threats for raising concerns, disagreeing with internal norms

[200] Nurse, Public Inquir, Anonymised Employee 13 Witness Statement, par72, p.20.
[201] Patient, Public Inquiry, Anonymised Patient 03 Witness statement, par14, p.4.

or evading organisational constraints in favour of patient welfare. Employees anticipate negative consequences from their managers and supervisors for doing so. By way of some examples:

> 'you just didn't put your head above the parapet because you would be in trouble if you did.' [202]

> 'if you asked a Ward Sister for example "do you have enough staff?" she would always respond "yes" as the staff do not want to get into trouble.' [203]

One very clear penalty which can be discerned in the data is that of being ignored or excluded in some way by one's teammates or colleagues. There is evidence that those who sought to stand up for appropriate standards were discouraged and isolated (Public Inquiry Report, Volume 3). Staff within the hospital faced social sanctions from their peers or supervisors as a consequence. For example:

> 'I had tried to raise this issue but by this stage I was completely ostracised by the Hospital anyway.' [204]

> 'whenever I actually said something at the meetings the rest of the attendees would carry on as if I had never said anything.' [205]

> 'I was completely ignored and they carried out inspections without using the sheets prepared. To say that I felt ostracised would be putting it mildly.' [206]

As well isolating, ostracising or ignoring colleagues, employee sanctioning includes subtler, more underhand criticism. Taking an 'oppositional' or 'critical' stance, for example, can lead to one being labelled awkward or difficult. Doctors describe situations in which their disagreement with internal conditions or practices leads to this. For example, one doctor explains how:

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[202] Senior Executive, Independent Inquiry Report, Volume 1, par76, p.168.
[203] Non-Executive, Public Inquiry, Anonymised Non-Executive 06 Witness Statement, par8, p.3.
[204] Other Role, Public Inquiry, Anonymised Non-Executive 07 Witness Statement, par68, p.21.
[205] Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par25, p.7.
[206] Other Role, Public Inquiry, Anonymised Non-Executive 07 Witness Statement, par40, p.13.

> 'The response was always that we had to do what we were told and were "naughty boys" for objecting.' [207]

Raising concerns can cause one to be branded a troublemaker. Typically, another doctor describes 'intimidating' responses when they raised concerns and being 'viewed as being a troublemaker, rather than someone raising genuine concerns.'[208] What all this censure effectually does is characterise those who complain as difficult and condemn them as unreasonable. This diminishes the character or worth of the complainant and by association lessens or discounts the complaints that they are making.

The operation of such features can be seen in whistle-blower statements. For example, complaining about the internal environment resulted in one individual becoming heavily censured. They became labelled as 'not a team player' and a 'troublemaker'. As a consequence of such disapproval, this employee was not only sanctioned, but also felt threatened. To illustrate the point:

> 'If you care about your patients and your work, you had a problem (you were deemed as a problem!).' [209]

> 'I really had to fight for this issue, and felt vilified and intimidated for raising it.' [210]

This instance of whistleblowing indicates that the possibility of being censured by others for complaining, and the fears or anxieties associated with this (whether real or imagined), could be a significant deterrent from challenging internal norms which compromise responsiveness to patients' welfare needs. Dozier and Miceli argue that whistleblowing is prosocial rather than altruistic since it may benefit the whistle-blower (e.g. reputationally), may not benefit others and may be required by certain roles (Dozier and Miceli, 1985). However, this argument appears to be potentially

[207] Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par2, p.4.
[208] Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par95, p.21.
[209] Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par41, p.10.
[210] Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par46, p.11.

undermined by the extensive potential losses which whistleblowers may experience or perceive to be in place. Notably, moral rebels, who oppose the prevailing state of affairs by refusing to be silenced by it, are intensely disliked by their more obedient colleagues, who might not only accept the status quo, but also safeguard or protect it (Monin, Sawyer and Marquez, 2008). Those who rebel may be resented and vilified by those who comply (O'Connor and Monin, 2016). The presence of such antagonism towards this whistle-blower supports the argument that moral rebels may be intensely disliked or vilified by more compliant colleagues.

What this indicates is the possibility that an organisational agents' prioritisation of patient welfare over organisational expectations could contravene internal norms and precipitate strong sanctioning as a result of their doing. Where this is the case it would generate costly penalties for the altruistic prioritisation of patient need. These penalties might affect organisational agents' assessment of their ability to do so. They may be severe. They might even extend beyond the informal social action outlined above into more formal or legal action. Thus:

> 'One of my colleagues who also complained regularly was suspended after something happened on a ward. He had been fairly vocal in criticising the Hospital and I suspect the real reason behind his suspension was because he was becoming a problem.' [211]

Fear is clearly associated with such narratives. Organisational agents are fearful of being blamed or penalised. They are alive to the threat of being punished for complaining about having to deliver services in a particular way or varying the way such services are delivered in favour of meeting patient need. Importantly, their fears are stimulated by the intangible prospect of such events happening, not just their actual occurrence or reality. Such fears would be unconducive to altruism by means of their power to direct organisational agents' attention to the prospect of

[211] Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par52, p.14.

costly penalties for breaking rules or eschewing expectations, even where doing so favours patient care.

Fear can lead individuals to contract their mental focus, concentrate on potential risks or threats and adopt avoidant behaviours (Kish-Gephart, Detert, Treviño and Edmondson, 2009). In this case, there is evidence of organisational agents exhibiting such behaviours. One sees them contracting their attentional focus onto themselves, extracting themselves from situations, for example, becoming silent or withdrawing, and avoiding others. Whilst a causal relationship between employees' fears and such behaviours cannot be proven by the data, it is certainly plausible. Such fears would inhibit altruism by focussing agents' attention on their own state at the expense of users or making certain actions, such as complaining, much costlier than they might be. The costliness of an action can deter altruism. Feasibly, an organisation generating substantial fears or anxieties about the effect of one's actions could inhibit altruism by making it seem or feel too expensive.

7.3 Demanding Context Conclusion

In this case, high strain is evident in the extensive temporal or physical demands placed on organisational agents, as well as associated mental and emotional drains. Alongside that, low support within the hospital is characterised by a lack of tangible, organisational, cultural or relational support. The absence of relational support is evident in the suppression, bullying or sanctioning of organisational agents. The combination of high organisational strain, coupled with low organisational support, places significant demand upon staff. It creates an internal operational environment which has the power to significantly reduce agents' collective potential for altruism by means of its effect on their helping resources (see Table 6). The High-Strain-Low-Support dynamic encourages internal organisational practices or adaptions which inhibit altruistic or helping behaviour. Effectually, it constitutes a misalignment between users' helping needs and organisations' helping resources which is unconducive to altruism. The sense that one is under-resourced or supported is likely

to undermine one's altruism. It could damage the sense that one has capacity to help. High mental or emotional strain, in particular, leads staff to feel overtaxed or overwhelmed. It drains their affective or cognitive resources with which to help others. Alongside this, organisational agents also lack tangible physical resources. Cultural or relational support which might help them mitigate the strain they feel is also absent.

Table 6: Helping Resources in High-Strain-Low-Support Context

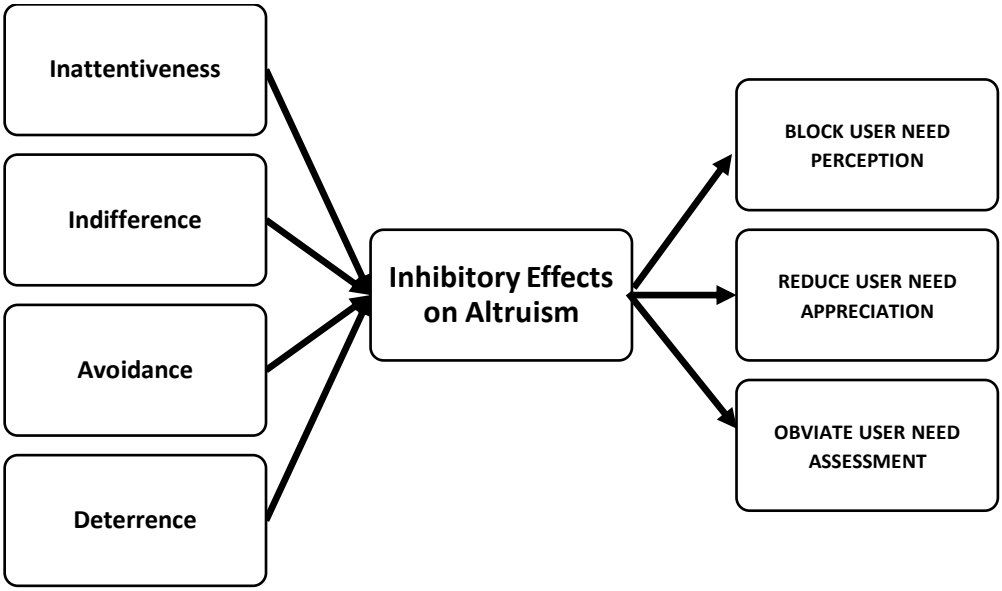
	STRESSORS	INFLUENCE ON ALTRUISTIC RESOURCES
1	**TEMPORALLY OVERSTRETCHED**	Organisational agents experience time pressures. Excessive temporal demands may reduce the time they have available with which to notice, appreciate, assess or respond to others' needs.
2	**PHYSICALLY OVERLOADED**	Organisational agents experience fatigue. Excessive physical demands may reduce their energy or capacity with which to respond to others' needs.
3	**MENTALLY OVERTAXED**	Organisational agents experience mental stress (or anguish). Excessive mental demands may reduce their cognitive capacity with which to notice and assess others' needs.
4	**EMOTIONALLY OVERWHELMED**	Organisational agents experience emotional distress. Excessive emotional demands (or over-arousal) may reduce their affective capacity with which to appreciate (or enter into) others' need.
5	**ORGANISATIONALLY CONSTRAINED**	Organisational agents experience increased organisational constraint. Reduced autonomy lessens their capacity to respond to others' demands or feel that they free to do so.
6	**ORGANISATIONALLY UNDER-RESOURCED OR SUPPORTED**	Organisational agents experience reduced cultural, relational or organisational resource. Resource related stresses and strains may reduce their capacity to respond to others' demands or feel that they are supported to do so.

Furthermore, cultural, managerial or relational unsupportiveness intensifies anxieties, directs agents' attention inward and creates a culture of threat and insecurity. Critically, this does not simply concern agents as individuals. It concerns them as a group. As a result, it depletes the organisation's collective capacity to notice, appreciate or assess organisational users' needs, reducing the possibility of altruistic responding.

8 CHAPTER 8: ORGANISATIONAL UNRESPONSIVENESS

This chapter explores unresponsiveness within the hospital. Institutionalised unresponsiveness may be considered a natural adaption to organisational environments which are overly demanding. In this case unresponsiveness is stimulated by the distracting emotional noise set out in Chapter 5, the de-stabilising internal conflict set out in Chapter 6, and the depleting and demanding workplace context set out in Chapter 7. Such conditions reduce organisational agents' helping capacity, lessening their temporal, physical, mental and emotional resources with which to aid others. Four un-altruistic practices emerge as a result of this organisational context. These are inattentiveness or indifference towards hospital users, avoidance of them, or the deterrence of them from seeking help (see Figure 14).

Figure 14: The Effect of Inhibitory Practices



These four practices reduce the attention organisational agents give to some activities, lower the priority they give to other activities and lessen their scanning for situations in which the welfare of patients might be compromised. They lower the

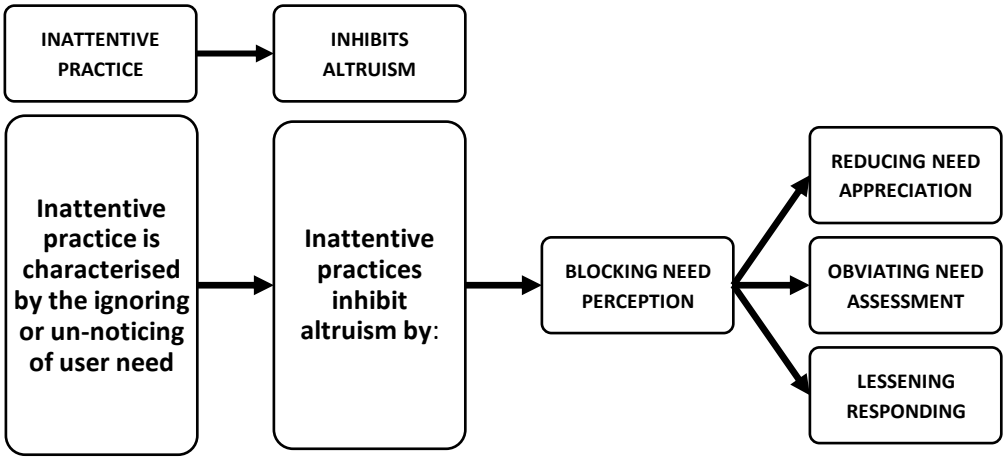
likelihood of patients' welfare needs being noticed by organisational agents. They reduce the chances of patients' needs being appreciated or entered into as a result of that. They also weaken the chances of patients' needs being assessed for the need to respond. It must be acknowledged that such effects would clearly impair good care. However, they also restrict the potential for altruism by making user need less visible or prominent and thus less likely to be recognised or considered. Such patterns of unresponsiveness fit with Korte's (1981) findings that people in overly demanding environmental conditions naturally respond with unhelpfulness. In this case, organisational agents adopt the same finely tuned unconscious adaptations which Korte identifies, such as walking through situations more quickly or reducing attentiveness to their surroundings. Presented with requests for help, they appear to be less likely notice them, too hurried to stop and offer aid or even committed to being uninvolved. Pertinently, this indicates the fundamental importance of attention, which is covered next.

8.1 The Practice of Inattentiveness

The first unresponsive practice evident in this case is organisational agents' collective inattentiveness towards users (see Figure 15). Inattentiveness is particularly evident in the way patients are ignored or neglected and their needs remain unseen or unnoticed. Inattentiveness is a practice which mentally detaches or distances organisational agents towards users. By such means, agents can consciously (or unconsciously) minimise their perception of internal helping need, manage any arousal or demand arising from seeing those needs and obviate any motivation or obligation to act. Such a practice is neither professional nor conducive to good care. However, it is also unconducive to altruism by means of its suppressive features. In particular, inattentiveness can block agents' perceptions of users' needs or welfare. In turn, that reduces the likelihood of their appreciating, or emotionally entering into, those needs. This would subsequently obviate any requirement for agents to assess the validity of users' needs or gauge their responsibility for responding. By such means, the motivational cues and inducements needed to simulate helping are

dismantled or robbed of their significance. As will be seen this section, organisational agents' cognition is directed inwardly to their own situation, making them introspective. It is also directed away from patient-related matters by distracting organisational factors. As a result, they do not look or scan for hospital users' needs. This means any signals which indicate that help is needed are less likely to encroach upon their awareness.

Figure 15: Organisational Inattentiveness in Action



There are a number of strands or elements to organisational agents' inattentiveness (see Appendix 14a: Cognitive Detachment). Agents, as a group, are characterised as mentally absent or abstracted. Witnesses talk of their 'going through the motions' or having 'no sign of life'. They are shown being absorbed in their own minor or trivial personal matters. For example, one witness describes nurses as 'more interested in checking their nails and mobile phones than the patients'.[212] They are also represented as preoccupied by more serious personal difficulties. For example, a manager explains how:

> 'people's jobs were not safe and everybody became wary.'[213]

[212] Relative, Public Inquiry, Anonymised Relative 01 Witness Statement, par58, p.18,
[213] Manager, Public Inquiry, Anonymised Employee 11 Witness Statement, par32, p.9/10

Agents' cognitive detachment from users is also evident in their reduced attention towards patients' symptoms and surroundings. They do not appear to look or scan for patients' needs or pick up on the cues or signals that help is need. Some of this inattentiveness is rare but serious. For example:

> 'When the patient was dying, no staff came to see or check on her condition and she was left to die on a noisy ward with visitors coming in and out. Not one member of staff noticed when the patient died. It was left to her daughter to check her mother's pulse, inform staff of the death and ask for her monitor to be turned off.' [214]

Generally, however, it is more day-to-day or commonplace. Typically, one relative describes how a family member's nutrition tube became blocked and this went unnoticed until they reported it.[215] Similarly, in a somewhat stranger example, a patient explains how, having become painfully entangled in her sheets, she was unable to get the attention of nurses and had to ring home for help on her mobile.[216]

The practice of inattentiveness can be seen in the operation of organisational routines, such as the buzzer system (See Appendix 9: Buzzer Routine). Buzzers are a means of communication which should facilitate help-seeking or giving by ensuring the visibility of users' needs, providing aural cues about patient welfare and signalling that help is required. Answering patient buzzers is clearly part of a healthcare employee's job. It is not altruistic. However, stopping to answer buzzers in an emotionally noisy environment exposes you to further, potentially excessive or unmanageable emotional distress. Doing so in a highly demanding environment may force you to make unpalatable choices between different aspects of your role. Both expose you to a potential diminution of your already potentially strained personal capacity or helping resources. In an environment of tense relations, if the patient whose buzzers you answer has expectations you cannot meet depleting conflict may

[214] Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.65.
[215] Relative, Independent Inquiry Report, Volume 2, p.32.
[216] Patient, independent Inquiry, Summary of Oral Evidence, Week 3.

arise. So, although answering buzzers is a requirement, in this context it comes with a cost for agents who can choose other less expensive options or activities. Stopping would only be deemed altruistic where the action is not only pursued to improve the welfare of users, but also chosen over other expectations of one's role which are perceived to have greater organisational priority, as well as done so in spite of the high-costs that would be imposed upon organisational agents for making such a choice.

Despite the requirement to answer buzzers, the data reveals a widespread group level practice of inattentiveness towards them (see Appendix 9: Buzzer Routine). A tendency for their sound not to be 'heard' or 'responded to' was a significant feature of the organisational environment (Healthcare Commission Report, 2009). The Trust was in the worst 20 percent of hospitals for the time taken to answer them in the 2005 Patient Survey.[217] Typically, patients explain:

> 'I was suffering from vomiting, I had been pressing the buzzer for a long time but nobody came.' [218]

> 'patients in his bay buzzed for nursing staff but no one came. Instead the patients had to shout to attract the attention of the nurses.' [219]

Along similar lines, relatives describe how they wait for hours for a reply to the call button or ring the buzzer for lengthy periods of time without response.[220] [221] Importantly, such inattentiveness impairs the perception of patient need. As well as buzzers being unanswered, relatives recount instances of them being placed out of reach.[222] [223] Whether purposefully or accidently, the device intended to make patient need heard is deactivated. Even if this misplacement is unconscious, it suggests a

[217] Independent Inquiry Report, Volume 2.
[218] Patient, Public Inquiry, Anonymised Patient 01 Witness Statement, par12, p.4.
[219] Patient, Independent Inquiry, Summary of Oral Evidence, Week 2.
[220] Relative, Independent Inquiry Report, Volume 1, p.394
[221] Relative, Independent Inquiry, Summary of Oral Evidence, Week 2.
[222] Relative, Independent Inquiry Report, Volume 2, p.23
[223] Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.43

lack of scanning for patient need or assessment of that need. There are even examples of more conscious manipulation. Thus, one patient explains how, when using her buzzer to get help for a patient whose buzzer did not work, the nurse said 'they had purposely not given this old lady a buzzer, she was a nuisance'.[224]

A similar pattern to the reduced scanning depicted for buzzers is also evident in other routines, indicating that inattentiveness is widespread, as well as systemically embedded into hospital routines. Take the medication routine as an example. Given the evidence of mistakes and errors, one can argue that this routine achieves its secondary purpose, which is delivering drugs, but not necessarily its primary one, which is correctly and uniformly medicating patients.[225] Environmental scanning does not occur. For example, users report examples of agents failing to check that patients know that their medication is there and that they need to take it or are able to do so. Those who are physically unable to medicate themselves, or lack the cognitive capacity to prompt them to do so, are not always assisted with this. This suggests that their incapacity has not been noticed or recognised. It implies either that those delivering the medication have not scanned the situation to identify their patients' capacity to medicate, or if they have identified an incapacity they have not ascribed themselves responsibility for addressing it. This pattern is highly evident in other routines, such as the systems for feeding or hydrating patients.

In considering inattentive practices, one must acknowledge the possibility that patients are neglected because staff are simply not present. As set out in section 7.2, constrained staffing levels reduce responding capacity. In the buzzer routine, reduced human resources are also an evident cause of neglect. Inadequate staffing levels is one of the strongest causes which witnesses attribute to buzzers being unanswered. Typically, one patient explains that:

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[224] Patient, Independent Inquiry Report, Volume 2, p.127.
[225] A third of those that came to the Healthcare Commission told them that patients did not receive the correct medication or were given the wrong medication (Healthcare Commission Report, 2009).

> ‘Nurses were so busy that ringing the bell was a pointless exercise.’ [226]

However, it is also possible that rather than being absent or occupied with other matters organisational agents are reinterpreting buzzers as interruptions rather than help-seeking signals. This would cognitively reduce their perceptual significance or importance. Illuminatingly, one employee describes a process of immunity to aural signals:

> ‘The effect was that the [REMOVED] contained significant numbers of patients in distress and, as a department, we were immune to the sound of pain.’ [227]

Such an example suggests that the situation has been reframed into one in which such sounds are no longer heard or, if they are heard, they need not be heeded. These pattern aligns with Milgram’s (1970) assertion that we adapt to excessive demands or inputs, by lessening the importance of certain contextual demands to make the overall number or load of inputs in any situation more manageable as a whole. Screening out buzzers significantly reduces temporal or physical demands on organisational agents, as well as obviating any mental or emotional demands associated with helping those who ring them. Failing to scan for patients’ ability to feed themselves, as is case with the food routine, achieves a similar effect (see Appendix 18: The Food Routine). Inattentiveness can thus be seen as an adaption to organisational conditions which protects organisational agents from demands upon them. This would simultaneously limit their opportunities for altruism.

A lack of attention to patient need is not just evident in the operation of organisational systems. Conversely, inattentiveness might also be shaped by such routines. Such an effect can be seen in admission procedures. These are characterised by: patients’ admission being delayed or omitted; users being ignored

[226] Patient, Independent Inquiry Report, Volume 2, p.128.
[227] Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement One, par13, p.4.

or neglected during, or while waiting for, admittance; and unresponsive or defensive communication between patients and those admitting them. The Four Hour Waiting Time Target, which forms part of the process, is especially problematic (see Appendix 17: The Four Hour Waiting Time Target). The target places significant expectation on employees coupled with reduced autonomy. It sets out a clear procedural requirement for processing patients within a specified timeframe. Staff must work at pace to meet it. Pressure to do so is intense. Organisational agents confirm:

> 'The pressure to comply with targets was huge.' [228]

> 'they felt pressured to prioritise patients who were close to breaching the target rather than prioritise by clinical need.' [229]

Stopping to respond to any patient need or distress unrelated to the target in this context exposes you to conflict with managers, supervisors and colleagues who are focussed on delivering it. Doing so could be altruistic because of the potential costs associated with rebelling in this way. Such costs include social censure, organisational sanctions or professional penalties.

Importantly, organisational inflexibility concerning this target also constrains organisational agents' autonomy to deploy their attention freely to patient welfare needs. Managers and supervisors clearly articulate an expectation that it will be met. As one doctor explains:

> 'The nurses were threatened on a near daily basis with losing their jobs if they did not get patients out within the 4 hours target.' [230]

It is explained that it was 'normal' for nurses to come out of meetings:

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[228] Manager, Public Inquiry, Anonymised Employee 09 Witness Statement, par34, p.12.
[229] Employees, Healthcare Commission Report, p.49.
[230] Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par10, p.3.

> ‘crying because they had been told that if they did not meet the 4 hour targets, they would lose their jobs.’ [231]

In its interviews with those working at the hospital prior to the inquiries, the Healthcare Commission (2009) found that they felt: that patient care was secondary to the achievement of targets or minimisation of breaches; that doctors were expected to treat minor ailments at the expense of more serious ones in order to meet such targets; and that they were pressured to prioritise patients who were close to breaching the target rather than deciding their treatment on the basis of clinical need. Critically, they were expected to report failures to meet this target. Pressure could be intense:

> ‘Nurses were expected to break the rules as a matter of course in order to meet targets’’.’ [232]

> ‘Rather than “breach" the target, the length of waiting time would regularly be falsified on notes and computer records.’ [233]

> ‘their response was extremely aggressive, basically telling me that they were in charge and accusing me, and anyone else who agreed with me, of not being team players.’ [234]

As these instances show, the consequence of pressures to meet such targets is twofold. Firstly, a gaming of the system emerges, with some staff falsifying records. Secondly, this is normalised, with some staff bullying and sanctioning organisational agents who disagree with that norm.

Such factors show how very strongly the organisation is directing its agents’ attention. As a result, one sees them deploying their focus to the time-related aspects of admittance procedures at the expense of human or clinical ones. The

[231] Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par10, p.3.
[232] Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par8, p.3.
[233] Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par8, p.3.
[234] Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par13, p.5.

genuine needs of the patients are overshadowed by a more immediate concern arising out of the hospital's internal expectations. By way of a specific example:

> '…a doctor was asked to work in "minors". At the time the doctor was administering thrombolysis to a patient who had suffered a heart attack. This doctor refused but was worried that a more junior doctor might have felt compelled to comply.' [235]

This particular instance shows how meeting the target for one patient takes precedence over the need of other more seriously ill patients. The latter patient's welfare need is clearly greater, but their 'need' is no longer the criteria for assessing helping responses. Human factors, such as the threat to a patient's health or the concern a doctor would feel about leaving them as a result, have been deprioritised in favour of meeting an operational target. Such an approach discourages altruism towards users by putting organisational expectation above their needs and then creating costly consequences for those agents who do not subscribe to this order of importance. However, it also fosters a distorted variant of professional practice in which patient need or welfare is eroded by organisational targets and expectations.

Overall, the Four Hour Waiting Time Target indicates a high level of organisationally generated attentional constraint. Collectively, agents' activity is structured around this target. Their cognitive capacity is anchored on meeting it. Their behaviour is directed towards delivering it. By way of illustration:

> 'As a result of each patient in the [REMOVED] having to be seen within four hours of arrival at [REMOVED], patients were moved to any bed that could be found to avoid there being a breach of the 4 hour target. This was even if the bed that had been found was not the most suitable for the patient….. some patients were moved up to four times in a 24 hour period.' [236]

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[235] Employees, Healthcare Commission Report, p.49.
[236] Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par84, p.23.

This anchoring reduces organisational agents' autonomy to scan for and attend to patient need. Acting automatically, in a routinised way, without scanning a situation, or questioning what is happening in it, will reduce one's exposure to the mental, visual, aural or emotional stimuli which would ignite compassion or motivate altruistic responses. By organising organisational agents' time with patients in a particular way, the target (albeit unintentionally) lessens their capacity to 'notice' and 'assess' what help is required more generally within their immediate environment. It removes the incentive to consider patients based on need and the freedom to align your actions accordingly. Critically, it appears to remove the 'judgement' element necessary for clinicians to assess who is most in need of help. Being organised along such lines would be unconducive to altruism. But it could also subvert good practice and undermine compassionate care.

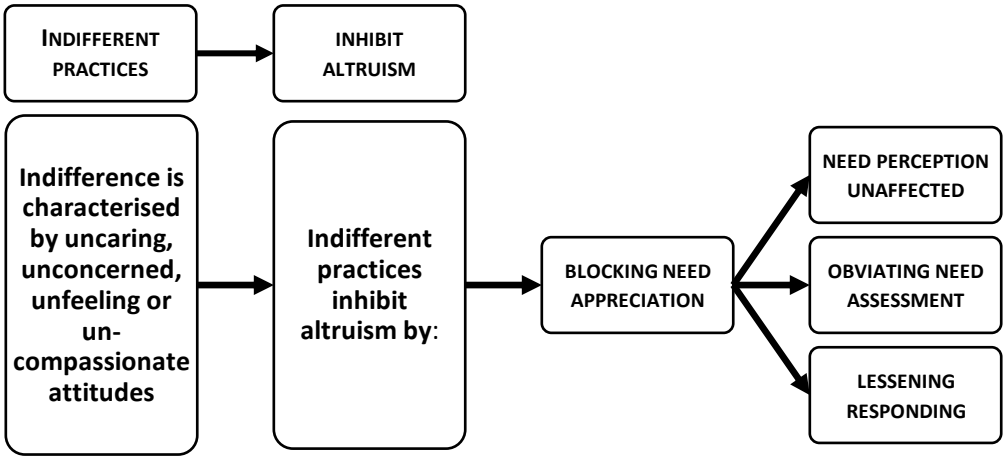
Notably, it is the organisation itself which is directing agents' attention in this way. Specific constraints promote inattentiveness towards patient need. There is a pattern to this. Firstly, a re-prioritisation occurs, in which delivering a target, and meeting management expectation, takes precedence. Secondly, the significance of patient need, which would be needed to stimulate helping, acquires a lower priority as a result. Thirdly, organisational agents' perception is redirected. Fourthly an absence of scanning can arise from this, an absence which is procedurally enabled. Thus, inattentiveness becomes embedded into practice by how the internal organisational architecture focuses agents' attention on the targets associated with routines, systems or processes, at the expense of attending to the wider welfare needs of the patients within them, and then normalises this focus. This practice is likely to increase the chance of patient needs being screened out.

8.2 The Practice of Indifference

The second unresponsive practice is this case is organisational agents' indifference towards users' needs or distress (see Figure 16). In this case, internal organisational conditions cause excessive arousal. Organisational agents face a substantial affective

load. As already shown in Chapter 5, they exhibit significant personal distress. That distress is derived from an emotional noisy environment, fraught with relational tension, in which they must meet significant demand with insufficient resources. As will be seen in this section, as well as cognitively distancing themselves from patients to make such demands upon them more manageable, organisational agents might affectively detach themselves to achieve a similar effect.

Figure 16: Organisational Indifference in Action



Indifference enables organisational agents to manage the negative emotional impact of others' needs or distress and reduce the requirement to respond should that distress feel overwhelming. Importantly, indifference does not prevent agents from noticing or seeing users need. Patients' need or distress may still be seen, however it is less likely to be ascribed significance. Indifference blocks agents' appreciation of need rather than their perception of it. It precludes concern. Critically, the emotional Inducements to provide help have been removed. Though not axiomatic, this could also lessen or obviate any requirement to assess need.

A number of strands or elements are evident in organisational agents' affective detachment from patients. Hospital staff are depicted behaving uncaringly or

unfeelingly, treating patients roughly or harshly, and acting coldly or insensitively towards them (see Appendix 14b: Affective Detachment). Most notable of all, in this case, compassion is typically referred to by its absence. Most references to it are negative and indicative of some absence, omission or failing. There is a clear discourse which describes professionals as lacking compassion towards hospital users. Witnesses speak of 'no compassion from the nurses' as a group, as well as specific staff who 'did not give us any support or show any compassion'. [237] [238] As one relative pertinently explains:

> 'It was lack of anything; compassion; nobody ever came in to see Mum and just say: how are you [name]? Which my Mum used to love. ….. … She liked a bit of fuss actually, if I am honest. But no, no compassion whatsoever.' [239]

Witnesses lexicon reveals a clear absence of compassionate actions or orientations towards users. Compassion, or related terms such as absence of, lack of or uncompassionate, are not uncommon. Antonymic expressions, such as uncaring, unconcerned or unfeeling are also used. Effectually, the language used by witnesses indicates that compassion, as an emotional or affective resource within the hospital, is much depleted or reduced. In its stead organisational agents' indifference towards users emerges.

Pertinently, indifference does not merely detach employees from patient suffering. It also has the power to influence their assessment of it, effectually reducing its significance. Thus, organisational agents are described as being unconcerned by patients' physical condition or discomfort. Organisational users talk of doctors who display 'little concern or interest' for patients and appear not to 'recognise or respond' to their symptoms. Many witnesses depict organisational agents as adopting unconcerned stances or orientations towards patients. They describe them

[237] Relative, Public Inquiry, Anonymised Relative 12 Witness Statement, par,12 p.4.
[238] Relative, Public inquiry, Anonymised Relative 07 Witness statement, par30, p. 7.
[239] Relative, Independent Inquiry Report Volume 1, par274, p.128.

'not being concerned,' showing 'no concern,' 'demonstrating little concern' and so on (see Appendix 14b: Affective Detachment). Typically, relatives describes how:

> 'The doctor demonstrated little concern or interest and, despite her mother's weight having ballooned and her condition having changed significantly, he did not appear to recognise or respond to these changes.' [240]

> 'when he went into hospital, we just got the impression: well, he is an old man, he is 80, it is not as if he has got a lifetime ahead of him, so why worry.' [241]

> 'In the hospital the nurses showed no concern that the patient was unable to eat.' [242]

Such instances show an indifference to patients' situation or personhood. Organisational agents are characterised as un-appreciative of their more personal human needs. For example, they do not appear to recognise that a patient might like 'a bit of fuss,' or prefer the help of a female nurse rather than a male one. Effectually, organisational agents' lack of concern for users is directed towards them as people as well as patients. The former might be typified by indifference to their fears or anxieties, while the latter might be typified by an indifference to their symptoms and the physical dependencies their illness creates. Importantly, if one is not attributing worth to people, or importance to their condition, then one is unlikely to be concerned by their situation. This means that even if one sees others as needing help one does not have to perceive it as significant, undertake any assessment of the need to act, or consider your responsibility to do so. Thus, cues that help are needed may still be perceived, but they are robbed of the significance which would promote altruism.

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[240] Relative, Independent Inquiry Report, Volume 1, p.44.
[241] Relative, Public Inquiry, Patient A Relative Witness Statement, p.129
[242] External organisation, Independent Inquiry Report, Volume 2, p.139.

Moving beyond this absence of compassion or concern, one also sees more actively demeaning and denigrating attitudes towards patients (as set out in 6.1 and 6.2). Occasionally, hospital users make more severe ascriptions of 'callousness' or outright 'cruelty'. In one example, the doctor is characterised as callously unengaged.

> 'the doctor was not so caring upon informing her partner of her prognosis, simply saying she "was severely brain damaged and expected to die sooner rather than later". When the patient contracted a chest infection her doctor initially refused to treat her, but reluctantly prescribed antibiotics at her partner's request. She did recover and her neurological condition improved, … The doctor's behaviour remained detached, only assessing the patient for a few seconds from the bottom of her bed.' [243]

Here a doctor is depicted as being dismissive of the patient's worth, as well as unresponsive to their clinical needs. This intimates a lack of human feeling towards both the patient and their relative. The former is shown in their apparent detachment, while the latter is evidenced by their communicating uncaringly and insensitively. Such examples imply that professionals are neither putting themselves into the position of those involved, nor appreciating the distress which their own behaviour towards users in such situations can cause. Patients' pain, in particular, may be being downgraded. As a whole, such behaviours indicate that if one approaches agents for help one will be dismissed. This would deter users from doing so.

Organisational agents' also express a degree of collective resignation or cynicism. There is an implication that they lack the ability to address the welfare needs of patients as a whole. Such apathy is evidenced in statements such as patients 'are going to die anyway.'[244] Should such feelings of inefficacy infuse their formal structural relationships with patients, it would encourage them to deny the remedial benefit of helping. Apathy directed in this way would undermine the functionality of

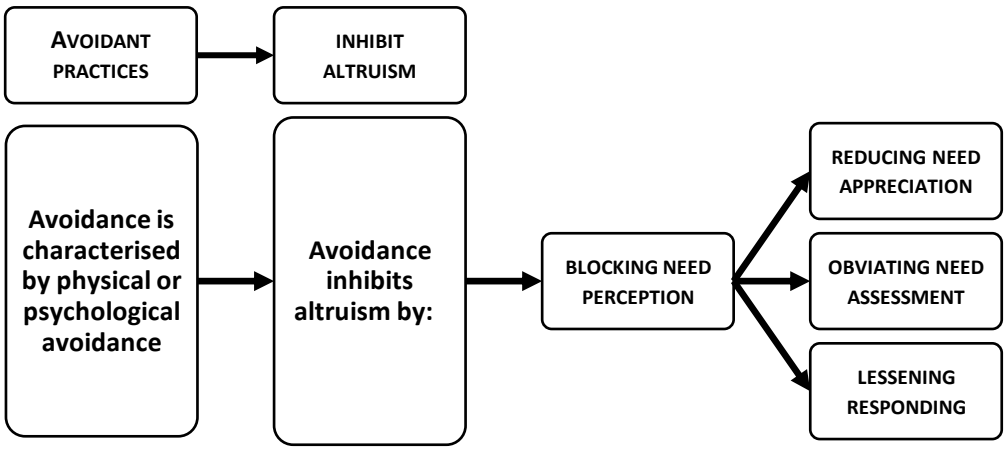
[243] Relative, Independent Inquiry Report, Volume 2, p.191.
[244] Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par47, p.14.

the patient-carer relationship. Critically, it suggests an erosion of the efficacy which normally promotes altruistic or helping behaviour. Along similar lines, organisational agents also exhibit a resigned stance towards their position as employees within hospital hierarchies. For example they say: 'there was no point' or 'nothing would ever be achieved'.[245] Importantly, they appear to adopt a negative orientation towards themselves as employees, towards the institution with its power over them as employees and towards their collective capacity to help patients.

8.3 The Practice of Avoidance

The third unresponsive practice evident in this case is organisational agents' avoidance of users (see Figure 17).

Figure 17: Organisational Avoidance in Action



As shown in Chapter 5 and 7, the hospital context is emotionally draining and highly demanding. In the circumstances, organisational agents may find the scale and

[245] Some examples of this are: 'There was a sense that nothing would ever be achieved by attempting to raise or report concerns.' (Senior Executive, Public Inquiry, Anonymised Employee 04 Witness Statement, par28, p.8) and '…there remained a group of clinical and health care staff whose general attitude appeared to be to be that there was no point reporting problems as nothing would be achieved.' (Other employee, Public Inquiry, Anonymised Employee 08 Witness Statement, par50, p17).

intensity of performance expectations unmanageable. In response, they can take steps to manage the volume of expectation, adopting behavioural strategies or practices which reduce it to a more feasible level. Avoidance is just such a strategy. Avoidance primarily inhibits altruism by means of its effect on organisational agents' perception of patient need. Though agents will be conscious of patient needs, avoidance lessens the chances or their being presented with them. Avoidance enables agents to manage the mental, physical, temporal or emotional demands placed upon them by a highly strained organisational environment.

The practice of avoidance is characterised by a number of strands or elements (Appendix 15: Avoidant Practices). Firstly, agents are shown avoiding certain situations, effectually eschewing contact with patients altogether. There are, for example, instances in which they are described hiding from patients, disappearing from sight, or otherwise making themselves physically unavailable. Thus:

> 'there was a lack of staff on the ward to ask and on one occasion a nurse refused to leave her office to speak to the family.' [246]

> 'On seeing the consultant in the corridor, they recalled that he hid in a linen cupboard to avoid, in their view, having to discuss her husband's case further.' [247]

By such means, employees can avoid perceiving any need at all. However, it is not always possible to avoid situations in this way. More generally, agents are depicted avoiding the demands which such situations precipitate by rushing through them. This is a second element of avoidant practice. As a group, organisational agents are characterised as being 'too busy' to help, constantly rushing around, hurrying past patients and so on. Associated with this is the practice of paying less attention to those within these situations. Thus, agents might shun eye contact, dodge requests

[246] Relative, Independent Inquiry Report, Volume 2, p.15.
[247] Relative, Independent Inquiry Report, Volume 1, par296, p.134.

for help or walk on by. They are frequently shown hurrying in ways that would reduce any contact. By way of examples:

> 'Nursing staff rarely spoke to the patient, but when they did they rushed and did not wait for her to answer.' [248]

> 'Nurses came and went but none of them seemed to want to look patients in the eye.' [249]

> 'although there were staff present on the ward, they seemed to be rushing around and the ward itself felt neglected.' [250]

In this case, there is a distinctive pattern of agents speeding up their walking pace, rushing past patients or reducing their visual or aural awareness. Rushing through a ward might mean not seeing a patient's troubled expression or hearing their distressed cries. Not seeing or hearing their distress signals might mean not having one's feelings provoked. Neither seeing, nor feeling any of this, would mean not having to assess patients' symptoms or requests for help and thus be obliged to respond. The point is that even when one has been propelled into a situation involving contact with hospital users, one can still minimise or reframe the level or nature of the contact one has with them.

In above pattern, organisational agents' avoidant behaviours lessen their perception of, or contact with, patients. Taking this one step further, however, if organisational agents cannot avoid certain situations, or eschew contact with users within them, they can still remove themselves or terminate their interaction with those involved. This is a third element of avoidant practice. By way of examples, one patient explained how a doctor's response was 'to shrug his shoulders and walk away' after she explained that she had no-one to care for her at home. By leaving, this doctor curtails their having to expose themselves to the patient's need and distress.

[248] External organisation, Independent Inquiry Report, Volume 2, p.273.
[249] Patient, Public Inquiry, Anonymised Patient 02 Witness Statement, 4a, p.3.
[250] Relative, Independent Inquiry Summary of Oral Evidence, Week 1.

Effectually, one can extricate oneself from being forced to appreciate their distress, or assess your responsibility for responding by walking away, rushing past, shrugging off contact and so on. In this third pattern, organisational agents may perceive users' need, and even appreciate their distress, however they also take steps to reduce the length of their exposure to it. So, although they see a patient's need, their appreciation of it may be dampened or down-regulated. Irrespective of which of these patterns is adopted, the requirement to assess need is obviated to a greater or lesser degree. Such patterns would not be conducive to altruism amongst healthcare professionals. Nor would they promote good care.

The practice of avoidance is evident in the organisations systems, processes or routines. Ignoring the sound of buzzers, for example, enables agents to avoid entering a situation which might generate demands upon their altruism. Unconsciously tuning out (or not hearing) the sound of the buzzers, allows situations to be modified into ones where such sounds are assigned a lower level of importance compared to any other activities in which one is engaged. Such modifications give one psychological permission to ignore or neglect patient welfare. They allow one to manage out the need to respond to this particular signal, thereby lessening the physical demands of doing so or the emotional labour which would arise from that. This could be deliberate or inadvertent. Buzzers might be overlooked because agents have focussed their attention elsewhere. Or the sound could be being more actively altered in meaning, reframed as a nuisance or reappraised as less important than other demands upon their time. Irrespective of the cause, buzzer avoidance removes organisational agents from help-seeking situations and inevitably reduces the potential for altruism. Notably, however, cognitively reframing or reappraising their sound would also enable organisational agents to psychologically avoid any self-sanctioning associated with acting in this way.

Avoidance is also embedded into practice by means of organisational constraints and in-group norms or sanctioning. These combine to make it permissible or even preferable for agents to prioritise the operational aspects of internal routines,

systems or processes at the expense of the human needs of the patients within them. In this case, avoidance appears to have evolved into a systemic level of unresponsiveness through the operation of organisational systems, processes and routines (see Table 7). Widespread omission or avoidance of certain steps within these appears to be normalised and commonplace. This institutionalises poor or unprofessional practice. However, by such means the need for altruistic or helping behaviour may also become less noticeable.

Table 7: Systemic Unresponsiveness

	AREA	SYSTEMIC AVOIDANCE
1	TREATING PATIENTS	• Patients are not admitted, diagnosed or treated. • Treatment is delayed, not undertaken in a timely manner. • Patients are precipitously discharged.
2	PERSONAL CARE	• Patients are not properly fed or hydrated. • Patients are not cleaned, groomed or toileted. • Patients care aids are not maintained (false teeth, etc). • Patients are left unaided or immobile.
3	MONITORING PATIENTS	• Patient conditions or symptoms are not monitored. • Patient records are not accurately maintained.
5	COMMUNICATING WITH PATIENTS S	• Patient (or relative) requests are ignored or neglected. • Buzzers are not heard or heeded.
6	MEDICATING PATIENTS	• Patients are not medicated, or medicated appropriately. • Patients are not provided with drugs in a timely manner.
7	REPORTING INCIDENTS OR COMPLAINTS	• Patient (or relative) complaints are denied or obfuscated. • Serious incidents and events go unreported and omitted from records, with mistakes repeated or not learned from.

Arguably, as well as reducing agents' ability or autonomy to scan for and attend to others' needs, systems, processes and routines actually offer a means to avoid them. Importantly, they provide staff with a means to deny responsibility for non-routinised actions, should they choose to do so, potentially inhibiting their openness to altruistic behaviour. Notably, an element of choice is involved. Organisational systems, process and routines can be consistently followed in a way which does not benefit patients. That could be considered systematic unresponsiveness to need. Alternatively, systems can be inconsistently discharged (or not followed) in a way which does not benefit patients. This would be a form of systemic breakdown. Either approach could feasibly hamper agents from paying attention to patients' needs. In

this case, one sees organisational agents adhering to organisational routines or procedures in ways which do not benefit patients. An example might be the rote collection of plates of uneaten food at mealtimes. One also sees agents inconsistently applying such routines or procedures to the benefit or detriment of patients. An example might be the medication routine where there is a perception that some nurses were helpful, giving out medication in advance when the drugs trolley was going to be late.

The complaints system is another site of avoidance. Complaints systems are a means of managing conflict inside organisations. They support the formal structural relationship between patient and user. They should manage the conflicts which arise from unmet needs or expectations and address any normative schisms between help-seeking or giving. They should help make formal structural relationships more effective by managing conflict between agents and users. Instead, the system protects organisational agents from the consequences of mistakes or neglect. In practice, the Trust was in the top 20 percent when it came to staff seeing mistakes or near misses, yet some incidents were not reported despite going to inquest, serious incidents were repeated and the board did not appear to discuss them (Healthcare Commission, 2009). Complaints and adverse event reporting were an organisational blind-spot. There are examples of this having serious consequences, for example a patient died after wandering off because employees were not aware of policies for missing patients despite this having caused death before.

Where complaints are concerned, however, avoidance is psychological rather than physical. It manifests itself in extensive denial. Analysis of the data indicates that organisational agents had a tendency to deny problems existed. By way of some examples:

> 'His family then noticed that the oxygen bag had once again gone flat. They shouted for help and they were ushered out of the room. An argument then ensued as the nurses denied that the bag had gone flat.' [251]

> 'After very rudely insinuating that I was lying throughout the meeting, [REMOVED] refuted that he had had his insulin changed saying that: "No he hasn't, no he hasn't, who told you that? At this point the diabetic nurse came along and confirmed that his insulin had in fact been changed.' [252]

In these examples, the employees concerned assert that oxygen is available when it is not, or that medication has not been changed when it has. Similar instances in the data indicate that organisational agents may deny that problems are real or genuine. There appears to be a cultural mind-set which is unaccepting of criticism, or the expression of users' concerns. By way of some typical examples which illustrate this point:

> 'there was a definite reluctance on the part of many members of staff to accept responsibility for their actions…..This culture of denial permeated to all levels of the Hospital.' [253]

> 'I was surprised by the level of denial within some parts of the Trust. I remember the phrase "It could have happened to any hospital but we were unfortunate to be investigated" being used a lot.' [254]

Insular cultures, characterised by inward-looking mind-sets, can protect an organisation, generating or reinforcing the sense that 'things are fine' when they are not. They provide a means by which organisational agents can avoid acknowledging adverse internal conditions and evade responsibility for addressing the deleterious treatment of users. By way of some examples:

> 'The Consultant told us at the meeting that he had not done anything wrong and if there was anything inappropriate about [REMOVED] care, it was not his fault but that of the nursing staff.' [255]

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[251] Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.177.
[252] Relative, Public Inquiry, Anonymised Relative 20 Witness Statement, par8, p.2.
[253] Senior Executive, Public Inquiry, Anonymised Employee 01 Witness Statement, par35, p.9.
[254] Doctor & Senior Executive, Public Inquiry, Anonymised Employee 17 Witness Statement, par9, p.4.
[255] Relative, Public Inquiry, Anonymised Relative 09 Witness Statement, par23, p.6.

> ‘overwhelming sense of denial... characterised by ‘it is not our fault, it is somebody else’s’.’ [256]

Notably, as these instances show, some organisational agents themselves recognise the existence of such a problem.

However, by denying the existence of problems, organisational agents can avoid having to accept the culpability which would arise from acknowledging them. The effect of this is twofold. Firstly, denying complaints protects employees from censure, whether that arises from their own self-chastisement or from another’s disapproval**.** Accepting complaints in this situation could be considered somewhat altruistic because it entails action which would further the welfare of users generally, while diminishing the welfare of any individual agents complained about. Importantly, accepting complaints imposes costly psychological penalties upon one. These might be the shame or embarrassment associated with recognising one’s own failures. Or there could be social costs, such as friction with one’s peers against whom such complaints may have been made. Denying these allows one to feel secure. One can avoid self-censure for conceding one’s own failings, or any guilt for acknowledging a colleague’s failings.

Secondly, however, denial forestalls any requirement to change one’s behaviours or undertake remedial action. Critically, where altruistic or helping behaviour is concerned, psychological avoidance affects one’s assessment of need. It reduces the obligation to accept that there is something to rectify or that that one is responsible for rectifying it. Thus, even if a relative brings a problem to your attention, and you are emotionally aroused or disturbed by their distress, you can rationalise action as unnecessary through your reframing or assessment of it. Extending this to an organisational level, where denial becomes an internal cultural norm it would a reduce capacity to appreciate distress as genuine. Importantly, by such means

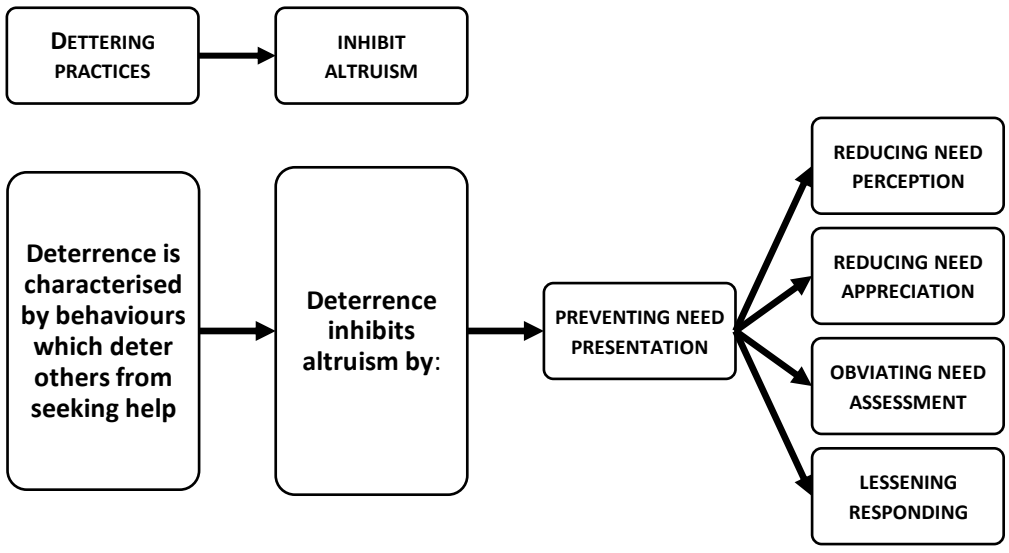
[256] Board member and Senior Executive, Independent Inquiry Report, Volume 1, par214, p.347

organisational agents can deny that users' concerns are valid, that there are actions which can (or should) be undertaken to address them, or that they have responsibility for carrying those actions out. It enables them to shift responsibility away from themselves and onto the people who are raising concerns or seeking help. By such means, a culture of denial would be unconducive to altruism. However, it would also be unconducive to good professional practice or care.

8.4 The Practice of Deterrence

The fourth unresponsive practice is this case is organisational agents' deterrence of users from seeking help. Deterrence inhibits altruism by means of its primary effect on the presentation of helping need (see Figure 18). Whereas some actions or behaviours allow agents to ignore or 'not see' patients' needs, or requests for help, others allow them to deter patients from seeking help or making their needs visible in the first place. As will be seen in this section, deterrence is a behavioural practice adopted by organisational agents towards users. It inhibits altruism through its influence on need perception, making those who need help less inclined to approach organisational agents for assistance.

Figure 18: Organisational User Deterrence in Action



As shown in Chapter 6, interaction between organisational agents and users can be inconsiderate or discourteous. There are many instances in the data which depict organisational agents assuming defensive stances or adopting more off-putting behaviours towards users (see Appendix 16: Deterrent Practices). They are shown being unwelcoming towards them, being actively disrespectful and even behaving threateningly. They are deemed unapproachable, repulsing patients from engaging with them and rebuffing relatives from seeking help on patients' behalf. Taken all together, such behaviours indicate that if one approaches agents for help one will be dismissed. This would make users feel uncomfortable about approaching any agent for help.

In keeping with the social influences which affect bystanders (Darley and Latané, 1968; Latané and Darley, 1968; Latané and Darley, 1969), users might worry about being misconstrued. They might want to avoid feeling foolish or embarrassed. It is clear that users are alive to such possibilities. There are instances, for example, in which it is clear that they are highly conscious of being mocked, belittled or patronised by staff. They seem sensitive to sarcasm or ridicule. In a typical example, a patient explains how:

> 'the nurse mocked her concerns and she was made to feel she was wasting hospital time.' [257]

In another, when a particular staff member is asked about a patient falling from their bed, they retort somewhat sarcastically that: 'we have had a man in here with no legs and he did not fall off the bed'.[258] In the first of these examples, a patient is made to feel like a time-waster and in the second a user is made to feel like an idiot. The point is that such treatment would make patients feel deeply conscious of themselves, as if they are being silly or unreasonable. That would deter them from approaching professionals for aid or assistance.

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[257] Patient, Independent Inquiry Report, Volume 2, p.22.
[258] External Organisation, Independent Inquiry Report, Volume 2, p.195.

In this case, harsher even more hostile behaviour towards users also acts as a deterrent. By way of example, one witness describes how a patient who kept asking for a doctor was threatened with eviction from the ward when she confronted a nurse about this.[259] In another example, a patient is effectually ordered not to need or ask for help, by being told to hold off from needing the toilet. At times, agents' behaviour is more subtly menacing. There are examples of them degrading patients, making thinly veiled insinuations or hinting at the prospect of reprisals. Patients express significant fear of this. Relatives describe how patients were frightened by this:

> '[REMOVED] did not complain about this at the time because he felt vulnerable and feared repercussions.' [260]

> 'I said I was going to complain. He got very, very agitated and distressed saying: don't say anything, don't say anything, they will take it out on me.' [261]

As seen in discussions of agents' distress and patients' diminishment (Chapters 5 and 6) there is also evidence of more actively aggressive or intimidating behaviour towards users. If patients fear that they may be even more seriously threatened, compromised or degraded they would be even less inclined to approach organisational agents. Taken altogether, such defensiveness would deter patients from seeking aid.

As already stated, organisational agents will be undoubtedly aware that hospital users have extensive needs. However, behaviour which deters users from making those needs apparent can effectually ensure that they are not presented. It excludes their needs or distress from agents' perceptions. In keeping with Milgram's theories (1970), in the same way that over-loaded urbanites block off various means by which others can engage with them, overloaded organisational agents may deliberately adopt off-putting behaviours to deter patients from engaging with them. Acting in

[259] Relative, Independent Inquiry Report, Volume 2, p.301.
[260] Patient, Independent Inquiry, Summary of Oral Evidence, Week 2.
[261] Relative, Independent Inquiry Report, Volume 1, par17, p.54

this way would enable them to avoid the mental, physical, temporal or emotional demands of interacting with patients as well as focus on other less draining, or more manageable, aspects of their work.[262] Here it appears to be an organisational feature which reduces the visibility or users' needs as a whole. It generates a collective overlooking or un-noticing of patient welfare, and normalises un-responsiveness towards them, or their relatives, as a result.

Deterrence is highly visible in the operation of the hospital complaints system (see Appendix 19: Complaints System Narratives). Analysis of this procedure reveals that users anticipate retaliation for complaining. They fear adverse repercussions or consequences for raising concerns. This includes being poorly cared for, generally neglected or exposed to even more actively hostile or aggressive behaviour. Examples of patients being ignored or neglected for complaining, or fearing that they will be, include:

> 'He had actually complained, hadn't he, about the treatment he had received from one nurse whilst there? And as a result this nurse totally ignored him for the rest of his stay; like she would walk by the bottom of his bed, he would ask for help or a drink and she just totally ignored him.' [263]

> 'Some of them were so stroppy that you felt that if you did complain, that they could be spiteful to my Mum or they could ignore her a bit more.' [264]

In the first example, a patient is ignored for complaining. In the second, a relative anticipates such an effect should they do so. Critically, the potential threat or anticipation of repercussions, as opposed to any retaliation which has actually transpired, is a deterrent. Users come to expect that complaining will result in hostile action or adverse care and treatment. To illustrate this point:

> 'mother told me not to say anything because she would still be there after

[262] Evidence of such adaptions in this setting is a intriguing contribution to the literature on altruism in healthcare.
[263] Relative, Independent Inquiry Report, Volume 1, par30, p.158.
[264] Patient, Independent Inquiry Report, Volume 1, par7, p.153.

we had gone home, and was scared the nurses would be mean to her.' [265]

'..she did not want us to complain when she was admitted to the hospital because she said that the staff would take it out on her and she feared retaliation.' [266]

Effectively, patients are being taught not to expect help from staff. This reduces the potential for altruism by means of its negative effect on the presentation of patient need.[267] Such a pattern would also be highly unconducive to good patient care. Moreover, its power to escalate internal emotional noise within the hospital, and increase conflict between agents and users, would be extremely strong.

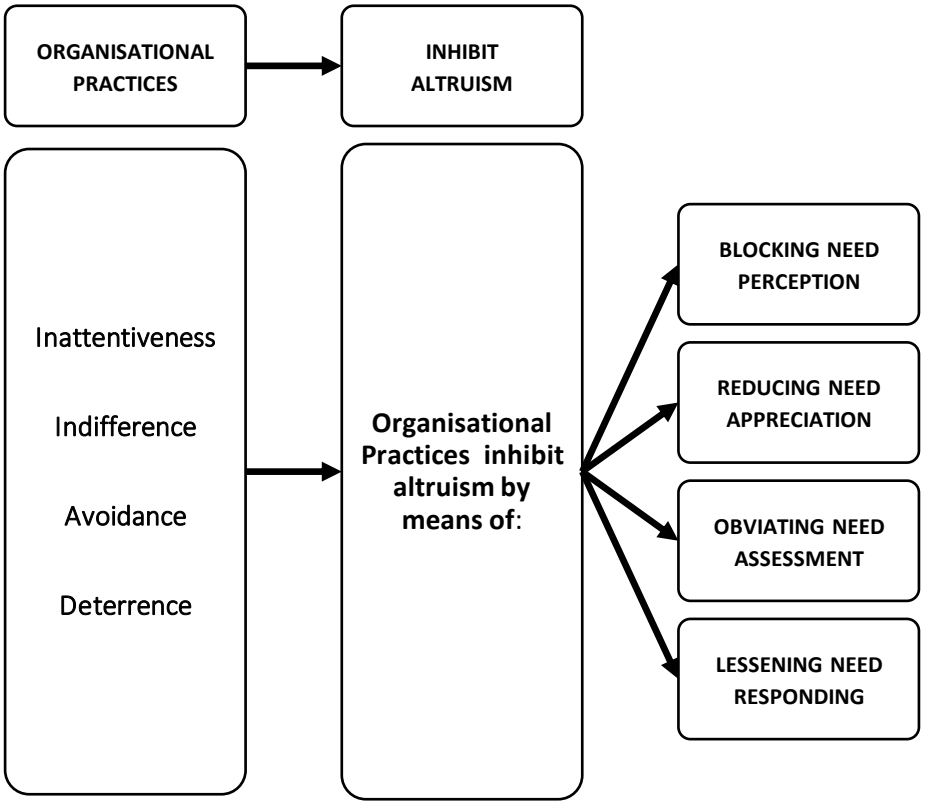
8.5 Towards a Model of Organisational Altruism

The previous chapters show that employee altruism is affected by strained organisational conditions or circumstances. Chapter 5 shows an emotionally noisy environment, which can obscure patient need and reduce agent capacity to perceive or process their distress. Chapter 6 shows groups locked in distracting conflict which lessens the significance of users or their needs. Chapter 7 shows that the demands of delivering organisational performance expectations in such a context, creates temporal, physical, mental or emotional strains which reduce agents' capacity to notice, appreciate or assess and respond to user need. This chapter set out the unresponsive states or practices which are created by such conditions inside the organisation. A summary of the effects of such practices is set out in Figure 19 on the next page.

[265] Relative, Independent Inquiry Report, Volume 2, p.151.
[266] Relative, Public Inquiry, Anonymised Relative 09 Witness Statement par12, p.4.
[267] By way of counterargument, patients might not be willing to complain because they have no wish to get employees into trouble, indicating a level of sympathy or compassion for that group. For example: 'there was very few care assistants on the ward that were caring, but the ones that were, you felt you had to look after, and Mum kept saying to my niece: don't make a fuss, you will get her into trouble, don't make a fuss. That's all she kept saying, even the following day when I came on. She said: leave it, leave it, you will get her into trouble.' (Relative, Independent Inquiry Report, Volume 1, par5, p.153)

In summary, the organisational conditions underpinning these practices are: distracting emotional noise, which is created by a demanding user group, highly distressed organisational members and internal chaos and uncertainty; de-stabilising member conflict, which is characterised by friction between member groups and dehumanised users; and extensive organisational demand, which is characterised by a high level of strain upon organisational agents coupled with low levels of support for them. This is termed a High-Strain-Low-Support context. Inherent within these conditions is an organisational culture or climate which is threatening and uncertain. Together, these conditions stimulate organisational practices towards users which can inhibit altruism. Those practices are inattentiveness, indifference, the avoidance of patients and the deterrence of them from seeking help.

Figure 19: Practices which Inhibit Altruism



Whilst some organisational conditions stimulate these practices, others also help to normalise or embed them. In this case, organisational routines themselves and certain group norms or sanctioning processes appear to amplify unresponsive practices. Their influence is most evident in reducing organisational agents' perception of need. That is achieved by how they constrain employee autonomy, direct their attention in particular ways, or normalise patterns of systemic omission or avoidance. Organisations can encourage responsiveness by organising their routines in two ways. They can organise them to allow the wider environmental scanning which would enable their agents to notice (i.e. see) and sense (i.e. feel) those needs which fall outside the auspices of the routine. Or they can incorporate a level of autonomy or flexibility for those undertaking them which makes additional, voluntary or discretionary effort more permissible.

Alternatively, organisations can focus agents' attention on meeting the narrower managerial or operational demands attached to such routines or processes, and direct their behaviour to delivering those, at the expense of noticing the wider human factors inherent in the situation within which they are being delivered. Anchoring organisational agents' attention on delivering the narrower target-related requirements of such routines and restricting their flexibility to decide how to do so is likely to create conditions which are unconducive to altruism. Attention to organisational routines, goals or targets may be high, but attention to the patient may be low, as is the case here. Arguably, as well as reducing employees' ability or autonomy to scan for and attend to others' needs, systems, processes and routines actually offer a means to avoid them. Importantly, they provide staff with a means to deny responsibility for non-routinised actions, should they choose to do so, potentially inhibiting their openness to altruistic behaviour. Notably, an element of choice is involved. So, the way that routines were normalised is also important.

Within organisations, situational clarity can be achieved through formal communication or informal norms which ensure that the expectations of employees are clear, understood and reinforced or supported by management (Meyer et al.,

2010). This situation appeared to lack clarity in a number of ways: wards were considered chaotic; information and administration appeared disorganised; users were confused and disorientated; rules, systems and procedures were, at times, unclear or unimplemented; and information was often deemed inaccurate, incomplete, or false. Informal norms can fill a vacuum created by an absence of formal clarity. They offer an alternative, informally acceptable, course of action to stated rules. informal norms can also shape the delivery of state rules or direct the actions and expectations of those delivering them. In this case, one sees a level of informally or normatively generated un-responsiveness. It appears acceptable or permissible to omit actions, take short-cuts, adopt work-arounds and so on when undertaking organisational routines. Such practices may be actively at odds with formally expressed intentions or procedures within the hospital. Organisations can create norms which are significantly harmful to 'outsiders' as well as at odds with wider ethical expectations or approaches (Dunfree, 2001). The adaptions identified in this section – of avoidance and inattentiveness - are potentially harmful to patients as an out-group, as well as at odds with their treatment expectations. However, such adaptions appear to have become commonplace. They are the norm.

SECTION V

9 CHAPTER 9: DISCUSSION

There are voices that it is no longer feasible or desirable to use altruism as a foundation for medical practice (Harris, 2018). However, the findings from this case indicate that it has importance as an organisational construct and potential strategic value in healthcare. This research set out to explore altruism at an organisational level. It began with very broad questions about what factors promote or inhibit altruism in organisations. The aim was to understand how altruism might be encouraged or discouraged inside organisations by their contexts or between their members. However, there were some key challenges to working with altruism as an organisational construct. While the literature review identified a broad range of organisational conditions that would be conducive to altruism, and certain practices which could promote it, it did not yield a comprehensive explanation of how it might be organisationally undermined. What was missing was an integrated model of the organisational contexts or conditions which would be unconducive to altruism, the internal practices which would inhibit it and how such factors might work together to the detriment of helping. This led to an increased emphasis on the second part of the question concerning inhibitory elements, utilising altruism's evident absence in the case studied.

The study findings converge significantly with the extant literature in some respects, however there are also some theoretically important points of divergence. The literature on altruism indicated that there is a critical instigational role for noticing in promoting helping behaviour. The findings supported its centrality. However, they also yielded a notable and striking contrast between organisational users whose noticing of patients was elevated and organisational agents whose noticing was lowered. This is where the case began to diverge from the literature. The organisational literature also indicated that altruism inside organisations could be promoted by practices in which members notice, appreciate and assess others' needs. Here a stark contrast emerged between users who acted in line with these predictions and agents who exhibited a different set of behaviours. Notably, users'

practices of noticing, feeling, and assessing others' needs, as well defending them from harm, provide an answer to the study question concerning what factors promote altruism. These will be referred to in the discussion as altruistic practices. In contrast, agents' practices, of inattentiveness, indifference, avoidance and deterrence, will be referred to as un-altruistic practices.[268] The way these un-altruistic practices work against perception of need, and contribute to an overall un-noticing of user welfare, is one of the most striking insights from the case. It answers the study question concerning what factors inhibit altruism in organisations.

The literature also indicated that organisational factors which might stimulate or suppress altruistic practices include an organisation's culture or climate, the architecture governing the delivery of its activities and the quality of relationships between its members, as well the quality or quantity of collective personal helping capacity or resources amongst its members. The findings from the case broadly supported the relevance of such factors in the inhibition of altruism. So, an organisation's conditions and its members' helping resources also provide answers to the question of what factors inhibit altruism. The study also yielded one significant augmentation to organisational conditions in the form of 'emotional noise'. This refers to the extensive level of emotional distress within the hospital which appears to act as a noisy distraction. Understanding of how all these factors work together is incomplete. More research is needed to ascertain how such practices, conditions and resources combine to inhibit altruism. An integrated understanding of that process is needed. This chapter has two sections. In the first section the findings are discussed, building towards a model of how such a process might work. In the second section, such a model is visualised as the foundation for further research and investigation.

[268] By way of a caveat, when the author speaks of agents' inattentiveness, and other such states or practices it is not intended to suggest all hospital staff behaved in this way, or that they did so on all occasions, rather it is intended to convey the point that such a pattern was perceived to be evident within the hospital. The same caveat applies to users.

9.1 The Organisational Inhibition of Altruism

The findings outlined in Section IV mainly focus on agents in line with this study's aim to prioritise understanding of the inhibition of altruism. In contrast, users' behaviour provides an answer to the study's question of what promotes altruism. However, users, as a group, also provide a theoretically valuable contrast to agents, as a group, through which to advance understanding of the latter. The findings concerning the user group dovetailed with a number of models in the literature concerning emergent altruistic practices inside organisations. This was an unexpected finding. Moreover, their range of helping actions were surprisingly extensive (See Table 8 on the next page). Underpinning them were practices in which users paid attention to other users' pain, experienced significant distress as a consequence of that, judged it appropriate that someone should respond and, at times, acted when agents did not. Thus, from an unanticipated source within the hospital, the noticing, feeling and responding practices predicted by compassion organising models still emerged as a feature of the organisational landscape (Kanov et al., 2004; Miller, 2007; Madden et al., 2012; Dutton et al., 2006; Way and Tracy, 2012; Lilius et al., 2012; Dutton et al., 2014).

So, the study's answer to the question of what promotes altruism inside organisations, in line with the predictions of the literature, is that it comes from members' altruistic behavioural practices which enhance their attention to, or appreciation and assessment of, user need. Though the finding is only in respect of users, and only amongst some of them, their altruistic practices are nonetheless sufficiently clearly delineated in the data to confirm the effect. One important inference which can be drawn from the emergence of such behaviours amongst users is that altruistic practices may still be strongly manifested inside organisational boundaries, even when they are not adopted by agents. This means that agents should not be seen as the only source of organisational helping, contrary to some approaches and, moreover, that more use might be made of such an effect.

A question which arises from this is why do users behave in the way which models of altruistic or helping behaviour inside organisations predict when agents do not? How can their behaviour, and its emergence, be interpreted? Is there anything in the differing contextual motivation of these two groups which might be used to help organisations encourage more altruism amongst either? Answering these questions could expand understanding of what factors promote altruism inside organisations.

Table 8: Summary of User to User Altruism

	TYPE	RANGE OF BEHAVIOURS
1	Monitoring patients and identifying problems.	Behaviours include: watching and monitoring patients' conditions; noticing, assessing and pointing out symptoms or problems; and even researching conditions or attempting diagnostics. Such behaviour indicates elevated attentiveness and heightened noticing.
2	Seeking aid or assistance for patients.	Behaviours include: seeking help for patients; demanding tests, checks or courses of treatment for them; querying and objecting to treatments taken (or not undertaken); and seeking alternative care options (i.e. going private, taking patients elsewhere, getting a second opinion). Such behaviour results from noticing and assessing user needs.
3	Providing physical or emotional care.	Behaviours include: undertaking hygiene and grooming for patients; feeding and hydrating patients; seeking medication and pain relief (or providing it); improving and/or providing a comfortable environment; and cleaning patients' immediate or wider environment. Such behaviour results from noticing and appreciating user needs. Compassion is evident in such acts.
4	Acting in emergency situations.	Behaviours include: noticing or finding patients in extreme situations; seeking help in the case of severe symptoms or events; intervening in dangerous or threatening situations; filling in staff gaps; and fixing, monitoring or operating equipment. This is precipitated by noticing such situations and assessing them as significant and important.
5	Punishing wrongdoing.	Behaviours include noticing and identifying infractions towards patients, criticising those responsible and bringing wrongdoing to the attention of third parties. This is precipitated by noticing such situations and assessing them as moral breaches.

In response, one obvious interpretation of users' differing behaviour towards each other lies in the potential motivation provided by their markedly different structural

relationship from agents. One would expect family members to monitor their loved one's conditions, seek help if that deteriorates and act if help does not arrive. Many of the behaviours set out in Table 8 were frequently undertaken by family members, in keeping with predictions of both kinship altruism (Hamilton 1964a; Hamilton, 1964b) and expectations of dependency relationships on altruism (Berkowitz and Daniels, 1963). That should be no surprise. If this were the main source of user to user altruism then organisations with significant populations of related users might be able to utilise such practices. However, the case indicates that family will be far from a complete answer in such circumstances. Altruistic practices extended beyond family members to other users, individually and as a group. So, although family may be part of the answer, other explanations are required.

Of course, there could be a role for simple proximity. User proximity to other users is of a lesser duration than agents, but nonetheless unavoidable. Propinquity, simply being close by for protracted periods of time, could well increase the likelihood of cues and signals being noticed. Users may respond simply because they are present and have the time available in which to observe a situation more fully. This would not be so much a feature of their being related, as of being present and also (in the short-term) unable to avoid noticing. There is limited escape from the sight of others' suffering during one's stay. So, arguably, one additional answer to the question of what promotes altruism inside organisations is inescapable proximity. It is hard for users to not notice. This might explain why they sometimes help when agents do not. That this constrained proximity is taking place in an adverse setting might also play a role. Setting user actions in the context of theories of emergency related helping suggests that the heightened nature of the events they are seeing could provide another explanation for their behaviour (Darley and Latané, 1968; Latané and Darley, 1968; Latané and Darley, 1969). Central to such theories, helping is contingent upon interpreting others' cues as emergencies. Extending interpretation of the case findings, users' high levels of reactive arousal, such as shock and alarm, to user distress signals, could be seen to constitute a form of contextually elevated

signal sensitivity. Though this is a matter of supposition, it appears plausible from the data.

Although proximity may be part of the answer, again it might not be the whole answer. As an explanation it fails to take account of more empathic possibilities suggested by the case. Many hospital users' reactions exceed simple personal arousal, showing marked levels of involvement and engagement. It can be inferred that they are not simply interpreting the events they see as emergencies, but also perceiving them with an element of other-orientated concern. Of course, the data cannot prove the motivational elements of such concern. But some reflections on its properties or construction are possible. There is an appreciation of other users' situations both as people with similar frailties and as patients with similar dependencies.[269] This indicates that such concern may be founded in sensitive cognitive engagement with the perspective of those in a similar situation in keeping with evidence in the literature that perspective-taking aids altruism (Krebs and Russell, 1981; Underwood and Moore, 1982; Galinsky and Moskowitz, 2000; Longmire and Harrison, 2018). The considerable acuity of such understanding evident amongst some users also suggests that recent conjectures about the importance of 'getting' perspective rather than merely 'taking' it (Eyal et al., 2018) are accurate.

However, alongside such cognitive appreciation, and at times in conjunction with it, there is evidence of clear affective appreciation. Users feel for other users. Given that the literature review indicated cognitive and affective responses alone are insufficient for altruism, their 'confluence' here may be a critical part of the answer to the question of what motivates organisational users to behave altruistically. So, another answer may be members' affectively infused cognitive understanding or

[269] The literature review also raised the question of whether organisational context plays a role in stimulating perspective-taking as a collective resource. The findings partly answer that question with an indication that elevated user understanding does appear to fuel elevated user to user helping, stimulated by an associated appreciation of context. However, the prevalence of this as a collective resource could not be determined by the study.

fellow feeling. Although it is tricky to confirm that this is a group effect because of the nature of the material, it is still possible to interpret users' behaviour towards each other as an empathic in-group effect of the kind which is predicted to promote altruism (Stürmer et al., 2005; Mathur et al., 2010; Singer and Klimecki, 2014).

A final part of the answer to why users act altruistically might be located in moral motivations. One interesting theoretical aspect which does emerge from this group is the practice of defending or punishing other users. Defending was tentatively discussed within the literature review, albeit mainly as a possible extension of un-altruistic practices and with questions as to its efficacy or functionality. Instead, the case provides insight into how such a practice might operate altruistically inside an organisation amongst users. User group defending is characterised by seeking help, demanding action, raising concerns and making complaints, often strenuously and persistently in the face of agents' disapproval or resistance. One could speculate that the case is hinting that elevated noticing will be accompanied by heightened moral acuity. Such behaviour is in keeping with the literature review's indication of a potential, but not axiomatic, relationship between moral, normative or cognitive assessments of situations and altruism. Since, in this case, such behaviour is usually precipitated by the treatment of others, rather than oneself, it supports predictions of the effect of moral violations towards others on observers' behaviour (Haidt, 2003; Hoffman, 2008; Kurzban et al., 2015; Lindebaum and Geddes, 2016).

However the duality of patterns of 'self' praise and 'other' criticism could also be interpreted as aligning with ethical models of organisational behaviour in which it is the combination of moral or normative judgements of oneself, as well as others, which can promote prosocial action (Schwartz, 1973; Treviño et al., 2007; Kish-Gephart et al., 2010). The inference one can draw from this is that altruism can emerge inside organisations, not only because of users' prosocial expectations of themselves, but also as a response to their simultaneous perception of agents' behaviour in keeping with, or out-with, their prosocial expectations of them. Put another way, users' altruistic practices may arise directly in response to agents' un-

altruistic ones. This is an illuminating inference which one might draw from the case. It suggests that there is a duality to altruism inside organisations. However, the limits of moral explanations pinpointed by the literature review do suggest some cautions should be taken concerning the validity of this explanation.

It must be acknowledged that defending or punishing behaviour is not helping other users per se. It can be interpreted differently, as action to sanction current transgressions in order to deter future harm. Extending beyond the findings of the case, in this respect it is feasible that users are operating in line with theories of strong reciprocity, in which actors mete out altruistic punishment in order to maintain expected levels of prosocial behaviour within groups or social institutions (Gintis, 2000; Fehr et al., 2002; Fehr and Gächter, 2002; Gintis, Bowles, Boyd and Fehr, 2003; Nowak, Vallacher and Miller, 2003**;** Feyr and Rockenbach, 2004; Nowak and Sigmund, 2005; Nowak, 2006; Jensen, 2016). In this regard, the case is open to an interesting interpretation. Strong reciprocators might be punishing wrongdoing inside the hospital to safeguard prospective users from future harm rather than simply protecting current users from actual harm. Although it cannot be proven, placing the case findings in the context of literature on strong reciprocity does suggest that defending practices could be less a case of protectively motivated altruism towards individuals as supposed in analysis of the findings, and more a case of broader social maintenance. Of course it could be either, or both, but this remains open to interpretation. Nonetheless, in answering the question of what promotes altruism in organisations, one unanticipated answer is an absence of altruism.

The case answer to what promotes altruism mainly lies in altruistic practices. The additional possibilities one can draw from this discussion is that user altruism can be motivated by their elevated noticing and heightened sensitivity to other users' cues and signals of distress, and that this elevation and sensitivity is likely to arise from a combination of their close proximity to each other as organisational in-group members situated in a commonly shared and adversely perceived emergency setting. This is the key insight from the case concerning user to user altruism. The

main implication of this for organisations is that their users will exhibit a different form of noticing, compared to that of agents, which is partly associated with their different structurally generated experience of the internal organisational environment. Importantly, they are likely to play close attention to harmful events, whether real or imagined, and possibly even closer attention to such occurrences than organisational agents themselves. Managers need to be sensitive to the possibility of such elevated noticing. They also need to consider its potential to negatively affect internal relationships where it arises in conjunction with harmful events which are capable of stimulating users' heightened moral acuity.

Such conditions may produce a hostile in-group, prepared to act defensively on behalf of members perceived to be subject to organisational mistreatment or neglect. The possibility that their altruistic practices are closely associated with agents perceived un-altruistic practice is a contribution to theoretical understanding of the subject on which further work is required. Hospitals, in particular, may induce altruism between their users by virtue of their poor professional treatment. One negative implication of this for managers is that, under conditions of perceived threat, users themselves will become an instrument of altruistic punishment directed at the organisation and its agents. For example, penalising them through public discourse. This was arguably evident in inquiry data, where 'condemnatory' narratives could be discerned. Such might be an indication of attempts to impose interpretation of events common to inquiries (Brown, 2004; Brown, 2005; Brown, 2018) discussed in the methodology. In this form, altruism may become damaging for the organisation. However, a more benign implication is that users could possibly be utilised more fulsomely as an internal support system for other users, given their elevated attentiveness. This would be in keeping with arguments that UK healthcare should consider drawing upon more altruistic public contributions to health and welfare services (Gormley, 1996; Riggs, Ubel and Saloner, 2017).

Before discussing the contrast which agents' un-altruistic practices present to users' altruistic ones, some important considerations arise in respect of the theoretical

challenge identifying them presented. The author had to overcome a lack of inhibitory altruistic practices within the literature against which to assess organisational behaviour. To do so, general theories about how altruism is inhibited were interrogated alongside organisational theories concerning promotional practices. Synthesising these two strands allowed the author to speculate that altruism would be inhibited when organisational members: collectively ignored or avoided other's needs; were unable to appreciate or enter into their distress; or eschewed any moral, social or ethical responsibility to respond.[270] Critically, in developing these suppositions, the author hypothesised that un-altruistic practices might be the converse of promotional ones. However, in contrast to the imprecision of the initial attempt to scope them from the literature, the un-altruistic practices which emerged from the study were conceptually much narrower and more precise. This is an important development.

One possible construction which can be made of these more precise un-altruistic practices is that there is indeed a direct, almost mirror-like, association between them and altruistic practices in the manner initially assumed. To explain, the literature indicates that noticing promotes altruism. The case confirms that with users, while at the same time indicating that inattentiveness inhibits it amongst agents. So, in line with the initial assumption, there is something of a reversal effect. However, in other practices there was no apparent mirror image. Deterrence, for example, as an inhibitory practice, cannot be straightforwardly matched with an opposing promotional force. It is surmised to be more inimical, scuppering altruistic practices themselves. To explain this metaphorically, in some cases altruistic and un-altruistic practices can be likened to using a steering wheel to sail a boat one way or another, however some un-altruistic practices might be better compared to a storm that makes it much hard to steer in a certain direction. Deterrence is one such. Such divergence between altruistic and un-altruistic practices indicates the necessity of a

[270] The practices were provisionally termed ignoring or un-noticing, detaching or distancing and disengaging or defending.

separate model focussed on delineating the organisational inhibition of altruism from its more general promotion. It confirms that the answer to what factors inhibit altruism, will not simply be the absence of those factors which promote it. This is an important contribution to the study of altruism as an organisational construct. It is one which has serious implications for managers. It implies that strategies for promoting altruistic practices and strategies for tackling un-altruistic practices will not necessarily be the same. Which means that the challenge of addressing a lack of altruistic or helping behaviour inside an organisation once it has emerged may require a very particular solution.

Moving on to consider the matter of agents' un-noticing of users' needs, and their un-altruistic practices towards them, medical institutions are contexts of acute risk, with potentially severe consequences. Such contexts are supposed to heighten the conscientiousness of those within them, especially those involving occupations where mistakes can lead to damaging outcomes (Meyer et al., 2010).[271] So, a hospital setting should axiomatically heighten agents' attentiveness. Noticing is a pattern which should be more evident in this case than it is. However, the absence of altruistic practices per se is not surprising given the study's purposeful sampling with that in mind. It is the way such practices work against perception of need, and their contribution to an overall un-noticing effect, which is theoretically illuminating. This forms the most striking observation from the case. It provides one clear answer to what factors inhibit altruism inside organisations. Building on the findings of the case, it is argued that un-altruistic practices are best understood in reference to their hindering effect on need perception, as a foundational precept for inhibiting altruism, in the same way users' altruistic practices are best understood with reference to their elevated and sensitive noticing of need as foundational condition for promoting it. Taking account of this centrality accorded to noticing or not noticing need, un-altruistic practices are defined as:

[271] In terms of situational strength, consequences are the extent to which the actions that individuals take, or the decisions that they make, will have positive or negative repercussions for others (Meyer et al., 2010).

> Practices which diminish the chances that organisational users will be physically noticed, emotionally appreciated or cognitively assessed by agents for a response to their need, distress or welfare. Such practices may be kindled by an organisation's context and conditions, or stimulated by the quality and quantity of its agents' personal helping resources.

Although inattentiveness, avoidance, indifference and deterrence were identified in this case, it is recognised that there may be other practices, or that some of these may be more or less important to the process than others.

Despite these caveats, in responding to the question of what inhibits altruism, the case contributes one clear answer in the form of these practices. The findings also shed light on how these practices achieve such an effect, through their role in reducing notice of user welfare. Whether consciously or unconsciously undertaken, they limit agent detection or discernment of users or their needs. Thus, the practice of avoidance, can ensure that agents do not see need at all. The practice of inattentiveness can ensure that they do not see need even when it is within their perceptual scope. There is something to see but it is not seen. Indifference would not prevent noticing per se. Such a relationship could not be confirmed by the study, though the possibility exists. However, it does reduce the significance of what is seen and obviate the need to pay as much attention. So, even if something is noticed, its impact is muted. The practice of deterrence puts off users from approaching agents, preventing need from obtruding upon their notice or at least reducing their duration of exposure to it. However, though not confirmed by the study, it is also feasible that deterrence could also be somewhat akin to indifference in obviating the need to see.

While the case findings demonstrate the impact of these practices singly, their collective power and interaction could be as, if not more, important. So, there is a need to evolve a more integrated understanding of how un-altruistic practices might work together. Responding to that point, there appear to be theoretically relevant differences between what such practices do. Some create un-noticing by protective means. Thus, inattentiveness and avoidance protect agents from having to see users or their needs in the first place. Need perception is blocked or eroded. Combined

these practices dismantle the necessary stimuli for altruism. Others create un-noticing by more defensive means. Thus, indifference or deterrence defend organisational agents from having to take significant notice of the users that they do see. Need perception is compromised rather than eroded. These practices change the nature of the stimuli. So, it could be said that the practices are having a markedly different effect on what user needs are noticed, how those needs are noticed (as significant or not) or the extent to which they need to be noticed. That difference may have implications for organisations about what strategies they adopt to tackle them. Taking account of these differing roles raises the question of such practices' holistic effects. Although all four are prevalent, it is not known if all four are needed. It is possible that altruism could be undermined by just one or two of these. It is possible that all four are needed because they address the different means by which need can obtrude upon one's notice, in one's physical sight, in one's mental landscape or in one's emotional hinterland. Or it could be that having just one of each of the two different types, that is one stimuli reducing and one stimuli changing, would be enough.

Moving on from organisational agents' practices, organisational conditions can also provide answers to the study question of what inhibits altruism inside organisations. In theory, organisations' conditions can affect how clear a user's need for aid is within their boundaries by situating them alongside other factors competing for agents' attention. They can also affect how significant such needs are perceived to be, by framing them with ascriptions concerning users as objects of greater or lesser worth. The organisational contexts and conditions explored in Chapters, 5, 6 and 7 set out how such factors, on their own, cause user need to become less noticeable to agents. Importantly, each factor can singly provide an explanation of why agents might be less able, likely, or inclined to notice user need. Thus, contextually induced un-noticing can arise from organisational demand and the way systems, processes or routines are misaligned to meet that. These might simply temporarily absorb agents' attention or more fundamentally undermine their broader situational attentiveness. Their role is as a potential cognitive distraction or constriction. Culture

is another source of contextually induced un-noticing. It might draw notice elsewhere. Again, its role is as a potential distraction. Relationships might offer support to manage the first two aspects or provide further distraction. So far, the findings did not diverge greatly from the dimensions established in the literature. However, the fourth condition of emotional noise is a new feature. This is expected to disrupt the clarity, force or impact of the distress of any particular user, or group of users in an organisation. Thus, somewhat akin to other contextual conditions, it has a potential role in distracting organisational agents from noticing users. So, in responding to the question of what inhibits altruism, the case contributes another answer in the form of how organisational conditions can reduce attention to users' needs or welfare. However, this answer also raises questions about whether such factors work differently, whether all of them are essential, whether some are more important than others and whether only one or two might be needed to inhibit altruism.

These are not questions which the study answers, though reflecting on the different ways such conditions appear to affect agents' attention, and distract or direct it elsewhere, can shed some light on them. Comparing and contrasting the differing effect of these conditions in the case yields three different properties. Firstly, they can distract agents' attention from users or absorb it elsewhere. This is a direct effect. Secondly, they can reduce agents' resources to attend to users. This is an effect through more indirect means. Thirdly, they might reduce agents' appetite to attend to users as a result of the first two factors. This is perhaps once again a more direct influence. So, they could be responsible for agents simply not noticing user need, or somewhat more complicatedly be responsible for agents not wanting to notice. Stratifying organisational conditions in this way indicates diverse possibilities concerning their potential influences on organisational agents' behaviours. In terms of their influence on what is noticed, organisational conditions could feasibly be typologised as attentional absorbers which direct agents' notice inwardly, attentional distractors which direct their notice elsewhere, or attentional depletors which reduce their personal capacity to notice. However, in terms of each

organisational condition's influence on what agents might not wish to notice, they can be typologised as attentional eluders, which agents can 'use' to direct their attention elsewhere should they not wish to notice users, or attentional demotivators, which reduce their personal desire to notice users and even generate an impetus to not do so. This further delineation of organisational condition's potentially varying operational influences extends interpretation of the findings. It suggests that they might have very different effects on agents' motivation, or be stimulating un-altruistic practices by very different means. Some conditions appear to be associated with all of these attentional effects, whereas others appear associated with just a few. For example, the findings indicate that helping need-resource misalignment could be capable of stimulating all of them. It is less clear whether emotional noise might do more than distract and deplete attention. There may be more potential permutations that the findings indicate.

Moreover, though such a typology helps indicate the different ways conditions are working, it cannot confirm how many of them would be needed to produce such an effect, or which might be most important in creating it. That said, a combination of them is probably required for the pronounced scale of the effect in this case. Given their potentially differing roles or effects, it is conceivable that only when such conditions align that such a powerful influence as un-noticing emerges. Arguably, much of their power lies in how they combine to produce a holistically highly demanding context which causes agents to not notice need, or not want to do so. However, although these conditions form part of the answer as to what factors inhibit altruism inside organisations, how they integrate to fundamentally undermine attention as an integral part of day to day organisational life still remains open to interpretation.

Overly loaded contexts, exceedingly demanding environments, or excessively distracting sensory factors, are indicated in reducing our desire to be involved with others, while simultaneously stimulating associated behaviours which increase the chances of our not noticing that they need help (Milgram, 1970; Korte, 1981;

Schroeder et al., 1995). So, it can be argued that they can stimulate both not noticing and not wanting to notice others' welfare needs in keeping with the findings from this case. Such a combination would be highly pertinent for altruism because of 'need' centrality. Claims of agent overload in an inquiry context could be regarded with some suspicion. However, in this case, validity can be also ascribed by means of users' confirmation of agents' claims. That confirmation is critical to this argument. In advancing a discussion of the combined effect of organisational conditions, it is important to clarify that load should not be seen only in respect of any misalignment between user helping need and organisational resources pinpointed in Chapter 7.

While misalignment is arguably the most concrete and tangible source of potential agent over-load, by means of its more visible temporal and physical effects, other organisational conditions can still add weight to the internal operational context. Moreover, potential interactions between them feasibly have the power to elevate the cognitive or affective effects of such misalignment. To give a hypothetical example of how such linkages might function as an integrating force, a threatening culture would make a failure to meet demand more costly for agents with potential social repercussions or sanctions. It would increase agents' personal arousal when seeking to manage conditions of helping need-resource misalignment. That culture might create, or even be caused by, relational conflict attributable to such misaligned conditions. Distracting emotional noise might arise from agents seeking to meet those misaligned conditions in the context of a threating environment with high levels of affective tension and relational strain. Many permutations of such potential interrelationships are possible.

Critically, the high load in this situation is one which can be considered not easily evaded. A closed situation is predicted to promote altruism towards others, but that will be lessened where there are avenues of escape (Batson et al., 1986; Batson, 1987). In a hospital, physical distance from users is impracticable. Agents will be routinely and habitually in close physical proximity to patients. Their cues and signals of distress will be extensive. So, this is a highly loaded 'need' based environment as

well as one in which that need is not easily circumnavigated. It is into this context that agents' practices can be interpreted as a means to control load by managing or minimising what they have to notice. In this respect, Batson's (2003) theories offer a means to extend the findings of the case, allowing such practices to be interpreted as physical or psychological escape routes from organisational conditions, which actively allow agents' to not notice, appreciate or assess cues concerning user welfare. Interpreted thus, the purpose of un-altruistic practices becomes that of freeing agents from having to cognitively or affectively notice users' need for help when they cannot easily evade sight of them by physical means.

One condition which agents might be seeking to escape within this highly loaded arena is emotional noise. As a newly added concept, emotional noise is put forward as an additional source of affective load or weight inside organisations. Based on the patterns of distress evident in the hospital, the findings indicate that an internal organisational terrain can be considered emotionally noisy in and of itself. Such a concept is in keeping with a growing body of evidence concerning the emotionality of organisations themselves (Fineman, 2003; Armstrong, 2004; Ashkanasy and Ashton-James, 2005; Fineman, 2008). However, since no consideration of emotional noise as a construct has been identified, an emotionally noisy organisational context is defined here as:

> A context in which organisational members collectively signal, perceive and anticipate an extensive level of distress, stimulated or exacerbated by the organisation's treatment of them or orientation towards their pain and suffering.

The concept of emotional noise raises questions for organisations about how it might be gestated within their boundaries. Since emotional noise, or emotionally noisy terrains, are conceivably more likely in organisations or industries which are sites of extensive pain, widespread suffering or pervasive and inescapable member distress, the concept poses a particular challenge for the caring industry. These organisations will have a higher degree of emotional noise because of the many sources of pain,

suffering and distress. However, organisations which are sites of extensive change or uncertainty might also be emotionally noisy, as could those which have experienced high levels of public scrutiny or criticism and become the focus of political debate. Notably, this case had all three. The concept provides a new potential source of answers to the question of what factors inhibit altruism in organisations which would be of particular value to those with highly affective environments.

So far, the study answer to what inhibits altruism is altruistic practices and organisational conditions. That answer raises the question of how such conditions and practices work together. As mentioned earlier in this discussion, there is a need to evolve a more integrated understanding of how the four un-altruistic practices might work together. Reframing them along the lines envisaged above, as an escape from constrained and inescapable organisational conditions, facilitates such an integration. Singly, they could be said to offer differing means of escape, with avoidance being mainly, but not solely a means of physically evading demanding organisational conditions, inattentiveness enabling a cognitive evasion of the mental pressures inherent in organisational conditions and indifference allowing an affective flight from the emotional claims or exigencies inherent in organisational conditions. Deterrence could be a physical means of escape, like avoidance, in that it prevents users from seeking aid from agents. But it could also feasibly be an affective source of escape, somewhat like indifference, infused as it is with emotions such as anger. To put that more simply, instead of deterring people because one is angry with them, one might be angry at them in order to deter them. Reframing organisational conditions and agents' practices interacting in this way reinforces the theory that no one practice would be enough on its own to inhibit altruism because they address the different means by which need can obtrude upon their notice, through one's physical sight, mental landscape or emotional hinterland. Combined they create a flight from need proximity.

Of course one needs to ask why evading proximity is so important. Explanation may be found in Milgram's studies of obedience which show that the closer you get to others the harder it will become to harm them.[272] This led him to propose that such an effect might be explained by: the presence and immediacy of visual cues and signals; a narrower cognitive field, in which the closer people are the harder it is to deny their suffering; or a reciprocal field of action, in which it is harder to harm a person who can see you harming them, since their surveillance of you might provoke shame or guilt (Milgram, 1965; Milgram, 1974). Reframing his interpretation, one might argue that the more distance we put between ourselves and others the easier it is to 'not' see or help them. Effectually, the less individuals are forced to see the cues and signals of another's distress the less they have to proffer aid. This means that not noticing can be a highly beneficial response to certain organisational contexts or conditions. Irrespective of whether such escape is consciously or intentionally pursued or unconsciously and inadvertently adopted, agents may simply not want to see. Although the findings fall short of being able to confirm such motivation, the plausibility of it can be argued on a theoretical basis. Moreover, the case implies that organisational agents' un-noticing could be a habitual adaption to such highly loaded contexts, with agents permanently modifying their behaviours to manage, minimise or escape the mental, physical, temporal and emotional calls upon their time and energy which such conditions create.

Using this revised interpretation it is possible to draw out one final insight from the findings concerning how agents' practices combine amongst themselves, and in response to organisational conditions, to produce a more habitual un-noticing effect. Firstly, a nurse who physically avoids users will be less likely to notice their cues. The presence of patient signals of need would be lessened. So, it would become easier not to help. Secondly, a nurse who is less attentive towards patients, would contract

[272] Testing four conditions of unseen and unheard subjects, heard but not seen, seen and heard, or seen, heard and touched, Milgram identified a pattern whereby the greater the contact (or closeness) the more likely it was that participants would refuse the instructions of the test co-ordinator to harm learners (Milgram, 1965; Milgram, 1974). Since most consideration of these studies focuses on people's willingness to harm others, the nuances concerning their decreasing willingness to do so under these conditions is often lost in discussion of his work.

their cognitive field, making it easier to deny user needs since they are less likely to be confronted by them. Or their cues might only be partially or tangentially perceived by such inattentiveness and thus still be present but far less immediate. Thirdly, as a result of these behaviours the nurse would not see a patient see them not helping them. Actions of avoidance and inattentiveness would, if conjoined, feasibly reduce their perception of any surveillance of their inaction. Though one cannot be sure of the motivation, nor attribute these behaviours to conscious deliberation, such patterns hint at distinctive psychological and emotional benefits which might encourage un-noticing, especially in respect of the self-censure which could arise from being made conscious of one's own unhelpfulness. So, instead of arguing that agents are not attending to users because they have not noticed them, this case offers the possibility of an entirely different perspective. It offers the option to infer that agents are more intentionally not noticing users in order to be able to not have to attend to them. Arguably, that would be the point of an un-noticing effect. Moreover, reducing surveillance could also simultaneously reduce any feelings of shame that might arise from seeing others see your unhelpfulness or deliberative un-noticing of them. A point I will return to later in this section.

Moving on from the contribution of conditions and practices to the inhibition of altruism inside organisations, the last potential answer provided by the study lies in organisational members' helping capacity or resources. The literature review of individual traits predicted that the potential for altruism would be affected by the level of organisational members' personal helping resources, cognitive, affective or otherwise. The findings provide support for this effect amongst agents. However, this feature is one of the hardest elements in the findings to validate. Direct correlation cannot be confirmed between agents' personal resources and helping behaviours, even though a pattern of depletion appear alongside a pattern of un-altruistic practice. That said, users observing these two patterns do, at times, infer connections between them. They can be seen making associations between their perception of agents' depleted mental, physical, or emotional states, and their perception of agents' reduced capacity or appetite for helping users. However, that

is still not confirmation. Moreover, instances in the data are not extensive. So, it is not possible to say with complete certainty which organisational conditions deplete which helping resources, which resource depletions generate which un-altruistic practices, or conversely which un-altruistic practices protect agents from the depletion of which resources. Furthermore, one cannot say with certainty which depletions are more important in their effect on the extent to which agents do, or do not, notice users' needs, whether it is enough if they are present singly, or whether the effect requires a reduction of all such resources. Further investigation is needed. What one can argue with more certainty, drawing on the findings from the case, is: that depleted personal resources do appear to play a role in inhibiting altruism by means of an ability to affect what needs are noticed and how; that the depletion of such resources is contextually generated; and that such depletions appear able to play a role in the evolution of un-altruistic practices. Thus, another answer to the study question is that where agents exhibit a reduced level, or degraded quality, of personal resources with which to help users, less attention will be paid towards them as a group, un-noticing may emerge and altruism can be inhibited.

The one resource which merits further discussion despite the aforementioned limitations of the findings concerning agents' helping resources generally, is affective resource. Building upon the discussion of emotional noise, the affective property of organisational life in this case appeared highly significant, with agents experiencing continuous proximate exposure to pain, suffering and distress. In this respect, the findings from this case dovetail with theories regarding the role of excessive emotional arousal in inhibiting altruistic or helping behaviour, even if they do not prove it. Agents' emotional characterisation in this data, as well as their behavioural practices, fit with Hoffman's (1981a, 1981b) theory that excessive emotions will direct people's attention inward, occupy them with self-regarding emotions and focus them upon their own personal state. While causality cannot be proven with the data available, high levels of agent distress are evident alongside their adoption of defensive practices, such as avoidance, as predicted (Hoffman, 2008). Self-

regarding emotions, such as fear and anxiety or anger and frustration, can be detected in conjunction with such practices.

Although this case was not designed to study emotional labour, it responds to a body of work showing that emotional labour or emotion work is a significant expectation of organisational agents working in health related or caring professions (James 1992; Bolton, 2000; Henderson, 2001; Brotheridge and Grandey, 2002; Larson and Yao, 2005; Theodosious, 2008; Erickson and Grove, 2008; Diefendorff, Erickson, Grandey and Dahling, 2011; Kessler, Heron and Dopson, 2015). Despite the need for that resource, emotional depletion or exhaustion is a common feature of professionals working within healthcare (Hall, Johnson, Watt and O'Connor, 2019; McKinley, McCain, Convie, Clarke, Dempster, Campbell, and Kirk, 2019; Vincent, Brindley, Highfield, Innes and Suntharalingam, 2019). Compassion in particular is extensively diminished (Van Mol et al., 2015). Moreover, emotional labour is indicated to drive much of this emotional depletion (Grandey, Foo, Groth and Goodwin, 2012; Bria, Baban, Dumitrascu, 2012; Rogers, Creed and Searle, 2014). Fineman conceptualises organisations as emotional arenas, in which emotions can be considered a 'strategic resource' capable of supporting or disrupting the internal social order (Fineman, 2008). Drawing these threads together, it appears that there is a damaging asymmetry between the quantity and quality of agents' affective capacity available inside healthcare organisations and users' demand for it as a resource. That asymmetry needs to be accounted for when analysing the findings. The case supports such a supposition. In this respect, it reveals a mismatch, in the example of compassion, between the emotional labour expected and the emotional labour which was seen to be undertaken. This damaging asymmetry, and the depleted level of affective resource it indicates, may explain a number of elements in the case which are less well explained by other factors.

In particular, it may shed light on the purpose of agents' diminishment of users, and how this functions in relation to their indifferent or deterrent practices towards this group. The findings indicate that organisational agents adopt defensive mind-sets

which would enable them to deny that patients' needs are genuine or deserving. Whether they are diminished to make un-noticing possible can by no means be irrefutably proven. Agents' behavioural patterns dovetail with theories that one can defend oneself by distorting one's perceptions of the situation, in particular by dehumanising, derogating or devaluing the victim, to make it morally permissible to treat them differently (Lerner and Miller, 1978; Schwartz, 1973; Stanton, 1998; Zimbardo, 2007; Reimann and Zimbardo, 2011). Despite the problem of proving any associations with agents' affective hinterland, one can still speculate on how this would work in relation to un-noticing. Diminished users can be seen as less important or significant. Their diminishment would justify paying less attention to them. It is not being suggested that hospital staff deliberately or collectively set out to 'not see' patients. Rather, if a patient can be considered a 'nuisance', a 'whiner' or one of the 'worried well' then less attention can be paid to them. An illuminating example in the case concerns an elderly patient who was given a broken buzzer because they were a 'nuisance'. This appositely illustrates that they do not need to be noticed so much because of their reduced significance. If one can see certain patients on the ward or groups of patients in the hospital as less deserving of notice, one does not need to look around so intently or assiduously while passing by them or provide them with a means of gaining your attention.

In the study, user diminishment was positioned and analysed within the findings on relational conflict, and thus a causal factor in the inhibition of altruism. However, its role could be more nuanced and multifaceted. Considered along the lines above, user diminishment might be not so much an organisational condition, as potentially more of a rationalisation with which to justify un-altruistic practices. In keeping with theories concerning the importance of contracted moral spheres, such diminishment is also conceivably a means of avoiding personal self-inflicted sanctions or social censure by recasting the nature of others in order to absolve one of imputations of misconduct when being unhelpful (Bandura, 2002). Critically, if one interprets user diminishment in the context of such theories, it lessens the need to notice, but without self-inflicted social or emotional penalties, such as shame. Such practices

can make it acceptable to not notice or see users. The reduction of users' significance as a group makes un-altruistic practices more permissible or less uncomfortable for agents. Arguably, it absolves agents of misconduct in not noticing users, for example, by placing users outside agents' moral order lessening any obligations towards them more generally. So, it can be presumed that an un-noticing effect will be elevated where user significance is reduced and reduced when user significance is elevated. Critically, framing users in these ways enables agents to avoid censuring themselves for 'not noticing' user need or paying less attention to it. Where there is less self-censure associated with inattentive or avoidant behaviours towards users they will become more permissible. Confirmation of this is not something which can be drawn from the study. Which leaves open the question concerning whether user diminishment is caused by the environment, and therefore a condition as set out in the findings, or a means of managing it, and thus potentially another un-altruistic practice, or both.

Delving into the emotions associated with this might help address that gap. Anger is a significant emotion evident in organisational agents' excessively aroused state. This was easily discernible because of the strong visibility of 'angry' cues and signals in the data. In this respect, agents' behaviours revealed a level of frustration with their own apparently 'unwarranted' situation which made them less helpful. It was a defensive force. Notably, anger can include the aim of correcting wrongdoing as well as perceiving it (Gibson and Callister, 2009). Arguably, it is possible that emotional depletion may be deepened by agents' inability to correct matters. If this is the case, that might explain user diminishment in keeping with scapegoating practices (Staub, 1985; Staub, 2004). However, one self-regarding emotion not so evident in the case is shame. There is but one specific reference to it, in which an organisational agent is described as 'shame faced'.[273] The omission seems noteworthy. The literature clearly links protective and defensive behaviours such as withdrawal and aggression with shame (Tangney et al., 2007; Lewis, 2008; De Hooge,

[273] Relative, Independent Inquiry Report, Volume 2, p.361.

Zeelenberg, and Breugelmans, 2010; Daniels and Robinson, 2019). Moreover, studies show a clear association between shame and defensive practices (both active and passive) in health services and caring roles or professions (Sanders, Pattison and Hurwitz, 2011; Gibson, 2014; Gibson, 2016; Cherry, Taylor, Brown, Rigby and Sellwood, 2016). However, in contrast to the literature, this case is characterised by the defensive practices associated with shame (again, both active and passive) while failing to provide any evidence of that association itself. One must ask why. Of course, it is possible that no shame was experienced but that seems unlikely. One possible explanation is that certain emotional cues and signals are indistinguishably interlinked.[274] Pertinently, Tangney and colleagues argue that shame and anger go together, since if you can blame others for your actions, or have the opportunity to take your anger out on them, you might be able to avoid feeling shame and in this way reassert a sense of personal control (Tangney et al., 2007). So, instead of agents' anger being prompted by their personal frustrations with patients, their theory would indicate that it might be provoked by their censure of themselves for not meeting organisational expectations towards patients which they share.

The case cannot answer this either way. But there is the possibility that emotional cues and signals which are being attributed to other-condemning anger in statements could also have been signalling self-condemning shame, or even both. Observers may be mistakenly (or less fulsomely) attributing emotional manifestations in their statements. This points to a clear limitation of using secondary data. If, however, the literature is correct in challenging the case in this way, it might ultimately explain why we see user diminishment. The extensive denigration evident in the case could be an indication of shame in line with the literature, albeit once again impossible to attribute. Despite that limitation, the inference or insight one might draw from this is that a critical role for user diminishment is managing shame. It is feasible that user diminishment is somewhat

[274] Other possible explanations lie in the comparatively limited visibility of shame-related cues and signals available in the data sources used. Precipitating emotions might also be blurry or imperceptible.

necessary for un-altruistic practices, especially those of indifference or deterrence, as a means of removing any consequential or resulting shame that would arise from adopting them. Considering the matter in this light, it may be a foundational condition for those practices or even a practice in its own right alongside them.

Pulling all the threads together concerning agents, it can be said that organisational conditions, organisational agents' practices, and organisational agents' resources, all provide answers to the question of what inhibits altruism inside organisations. However, their power appears reliant upon their intensifying effect when integrated. Integration is at the heart of how altruism might be inhibited. Together they create an 'un-noticing' effect in which the needs or distress of their users are neither perceived nor recognised as significant in order to manage the demands of responding to them. This is conceptualised as:

> An effect in which organisational contexts or conditions, and agent practices or resources combine to decrease users' visibility, prominence or significance, diminishing the chances that they will be physically noticed, emotionally appreciated or cognitively assessed by agents for a response to their need, distress or welfare.

As set out in this discussion, how the three factors do ultimately integrate procedurally remains a matter of some speculation. Moreover, there are numerous potential permutations for interaction between each condition, practice and source of helping resource which could have a greater or less impact on altruism by means of how they might combine to reduce perception, appreciation of assessment of need. Setting out all of them here is beyond the scope of this discussion. However, the process of procedural integration and interaction can be explained by means of a hypothetical analysis.

So, starting with the first condition, helping need-resource misalignment is factored into such analysis. A hospital unit could have fewer nurses on a ward than recommended protocols. In such a situation, nurses might avoid the calls of some patients on some occasions. However, if that misalignment is extensive and

unremitting, their avoidance might become common practice. Deterrent practices might arise if nurses habitually seek to put distance between themselves and patients as a means of managing this misalignment. Thus, un-noticing would begin. Turning to a second condition, cultural threats or instabilities are factored in. If the unit has to meet certain targets made more difficult to reach by the precipitating misalignment, nurses might become habitually absorbed by those, and less attentive to patients. So, un-noticing intensifies. Loading in relational conflict as a third condition is complex. However, nurses on the ward may not get on. This could deplete their personal resources, for example draining their affective energy through hostilities which arise over disagreements concerning how to respond to the targets. This could also increase affective strain between parties. Next emotional noise is factored in. This might overwhelm nurses in its scale and intensity, making them less concerned by the distress of any individual patients or colleagues. Indifferent practice might start to emerge.

By this stage, each organisational condition identified by this study is present. Potential effects are evident. Singly, they are acting as attentional absorbers or distractors which direct nurses' notice to themselves or away from patients. Combined they appear to be acting as attentional depletors, reducing nurses' personal helping resources. So, reduced personal resources are factored in next. If the nurses have reduced affective capacity as a result of all these conditions, they may be less inclined to attach any significance to the distress of patients. Indifferent practice may intensify. As the initial misalignment between demand and resource becomes more strained, affective resources would become further depleted, making nurses less and less keen to attend to patients' potentially draining distress. So, noticing becomes more draining, and un-noticing becomes much more attractive. User diminishment may arise as a result of nurses depleted or degraded affective resources, and in response to how draining it is to respond to patients. At this point, it would help to reconcile any self-censure that might normally be imposed by such actions, making un-noticing more permissible. Indifference or deterrence could then escalate as a result of patients' reduced significance or importance.

This is not an un-questionably validated procedural effect, but the findings strongly indicate its plausibility. It is proposed that such an effect inhibits altruistic responses by initially reducing the chance that organisational users' needs are perceived with significance and subsequently reducing the chances that agents will appreciate their pain, engage with their suffering or be motivated to act. Such an effect is likely to impair contact between agents and users and undermine the relational architecture upon which an organisation is founded. This raises the prospect that un-noticing could be responsible for user neglect inside organisations generally, not simply the inhibition of any altruistic or helping behaviour towards them. There are many implications arising from this. However, a distinguishing feature of un-noticing is that the effect can be conceived of as a more behavioural adaption to organisational contexts, driven by internal organisational conditions, and even, at times, deliberately adopted as habitual practice to circumvent them.

While it might be psychologically comforting for organisations to presume their agents do not help because they are too busy to notice users' needs, the implication is that they need to consider the possibility that such behaviour is more deliberately constructed in response to their physically close and inescapable proximity to intense levels of user need and distress within highly loaded organisational contexts. Thus, it becomes important for organisations to understand whether their staff are simply not noticing user need or more deliberately adopting practices which enable them not to notice it, or both. Importantly, the practices which arise from this not only appear capable of inhibiting altruistic or helping behaviour, but also appear capable of distorting professional practice. So, tackling their emergence in a hospital would be vital for good care.

9.2 Contribution and Research

Having embarked upon this study it became clear that what was most notably absent from the literature was a model which explained how altruism might be inhibited inside organisations. The model put forward in this section for further investigation

addresses that gap. It is the study's main contribution to the literature. It sets out which organisational contexts or conditions are unconducive to altruism and what practices might emerge as a consequence of these. There was considerable convergence between the broad initial dimensions for such a model predicted by the literature review and the more defined narrative themes which emerged from the case (see Table 9).

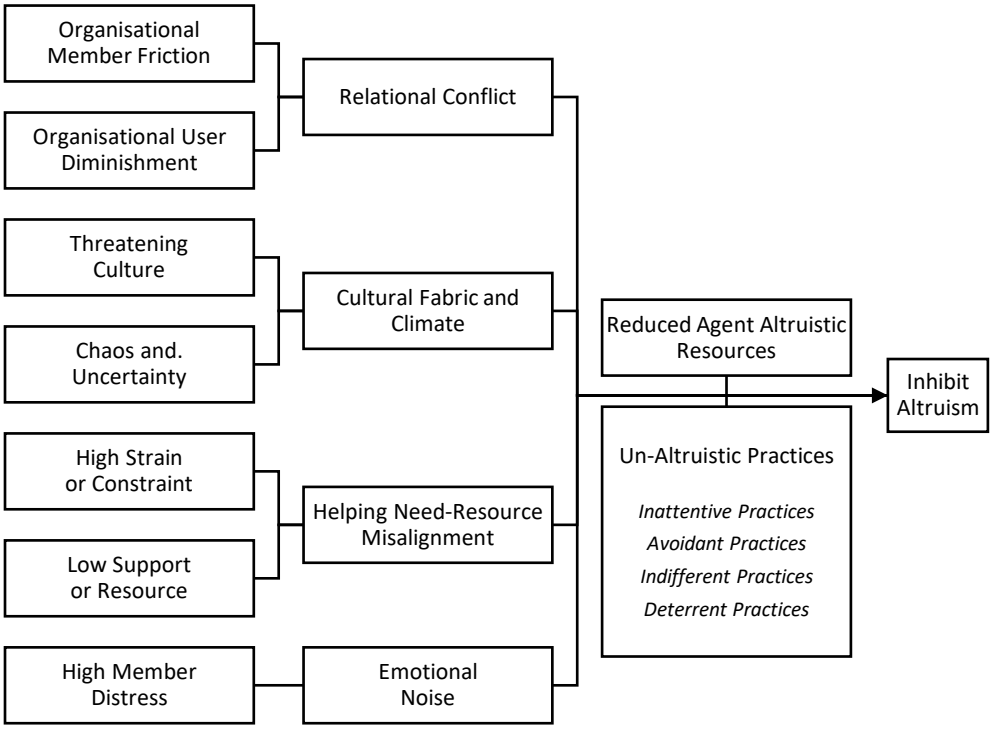
Table 9: Comparison of Case Findings with Literature Predictions

DIMENSIONS	REVIEW PREDICTIONS	CASE FINDINGS
QUALITY OF ORGANISATIONAL RELATIONSHIPS	• Agent to Agent Relationships • Agent to User Relationships • Organisational In or Out-Groups	• Conflict between organisational agents and users. • Some 'diminishment' of patients as an out-group. • Poor member relationships characterised by friction.
ORGANISATIONAL CULTURAL FABRIC	• Organisational Culture and Climate • Organisational Norms and Sanctioning	• Culture perceived as threatening or unwelcoming. • Context perceived as chaotic and unstable. • Normalisation of short cuts, omissions or workarounds, with sanctioning.
ORGANISATIONAL ARCHITECTURE	• Helping Costs or Rewards • Structural Autonomy or Constraints • Helping Need-Resource Alignment	• Potentially high costs (or low rewards) for helping users. • Constraints upon agent autonomy to help users. • High strain on agents coupled with a low levels of resource or support with which to help users.
MEMBER RESOURCES	• Collective Helping Capacity or Resources	• Low levels of personal helping resource amongst organisational agents.
EMERGENT ALTRUISTIC PRACTICES	• Practices of Noticing, Appreciating and Assessing.	• Use practices of noticing, appreciating and assessing and defending. • Agent practices of inattentiveness, indifference, avoidance and deterrence.
EMOTIONAL NOISE	• High levels of Member distress	• Emotional noise identified as a distraction for agents.

Nested within the model are four un-altruistic practices which were not present in the literature, as discussed in the previous section. These are the study's second contribution to the literature. One potential augmentation which emerged from the

study is also added to the model. This is emotional noise. The construct is the study's third contribution. A refined diagrammatic of the model is visualised in this section (see Figure 20).

Figure 20: A Model of the Organisational Inhibition of Altruism



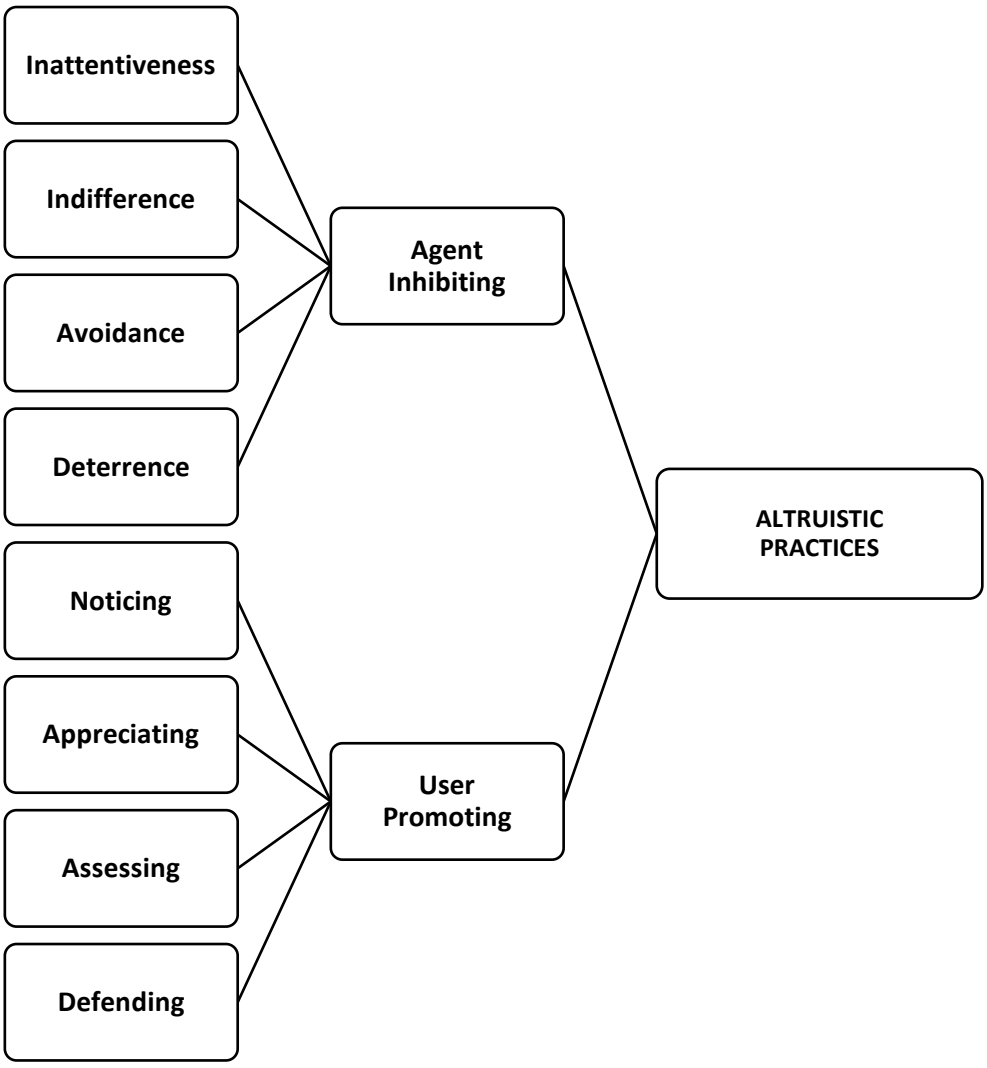
This refined model takes account of any pertinent differences between the proposed constructs for a model drawn from the literature review (see Figure 7) and the narratives themes which emerged in the findings (see Figure 10), as well as any plausible assumptions, additional possibilities or augmentations discussed in the previous section. The model now provides a platform for further research. One caveat must be explained. This concerns the position of culture within this refinement. Its inclusion is not in doubt. However, its placement is trickier. In the case, perception of a threatening culture appeared inextricably linked to demand,

and was thus hard to separate out from the misalignment between user helping need and resources created by the organisational architecture. However, chaos and uncertainty was a source of considerable distress to members and initially hard to separate out from emotional noise and agent over-arousal. Reflecting on the delineation of culture in the literature, keeping these two factors together within a cultural domain will make the model conceptually cleaner and easier to use for research. However, there is the possibility that such placement could be changed by further investigation.

There are five research themes arising from this model. These concern the model, its practices, its procedural integration, the interrelationships between its constructs and any new ones. The first theme for research concerns the validity of model itself. The model needs testing in other cases and in different contexts than healthcare. The second theme for research concerns the un-altruistic practices. There is a clear need to replicate the findings regarding the four practices nested within the model. The case convincingly indicates that these can inhibit altruism by means of their influence on what is noticed, possessing a power to reduce need perception, appreciation and assessment, or even block and obviate them. However, one case is insufficient to be certain that this is the complete and irrefutable explanation of their influence. Nor can it produce a complete typology of un-altruistic practices. Further research is needed into how such practices are created, whether there are more, which might be most important and whether all are required for altruism to be inhibited. Given the contrast between agent and user helping which emerges from the case, studies which explore the duality of practice indicated by the case would also be a potentially fruitful source of future research. The contrast is visualised here for reference (see Figure 21 on the next page). The possibility for mirroring between promotional and inhibitory practices discussed in the previous section is worthy of further research. It might reveal nuances in the practices themselves. Thus inattentiveness in relation to noticing, and indifference in relation to appreciating, merit comparative investigation. The addition of defending as a user practice also requires further exploration and considerably greater testing for validity than one

case study can provide. Moreover, as discussed in the previous section, the possibility that altruistic practice arises in response to the four un-altruistic practices merits further investigation.

Figure 21: Agent Versus User Altruism Comparison



The third research theme concerns procedural assumptions within the model itself. These require empirical testing and confirmation. Based on the discussion in the previous section, the model incorporates a number of procedural assumptions. Firstly, it is anticipated that helping will be inhibited by the routine or habitual

adoption of the four un-altruistic practices. Secondly, it is assumed that a depletion of organisational agents' personal capacities or helping resources with which to aid others, now termed altruistic resources within the model, will be a causal factor in the emergence of such practices. Thirdly, the model predicts that both altruistic resources and un-altruistic practices will be affected by the organisation's emotional terrain, cultural fabric, internal relationships and alignment of helping need with resource. In that regard, the model predicts that altruism will be diminished where an organisation's emotional terrain is noisy, its culture or climate is threatening and uncertain, its relationships are characterised by friction, its users are diminished in some way and the balance between their helping needs and organisational helping resource is out of kilter.

That predictive aspect of the model requires validation. This case follows that prediction, but one case is insufficient to confirm how such a process works, whether each of these organisational conditions is necessary, whether they are directly or indirectly involved, or both. Picking up on the latter point, it assumed that altruism is reduced because these conditions have a twofold influence, in which they may directly stimulate un-altruistic practices as habitual adaptions to the context they create or, alternatively, indirectly influence the process by depleting agents' altruistic resources within that context. However, again, such procedural assumptions need empirical confirmation. They are intimated by the findings, and plausible on the basis of the literature, but they cannot be considered confirmed by a single case.

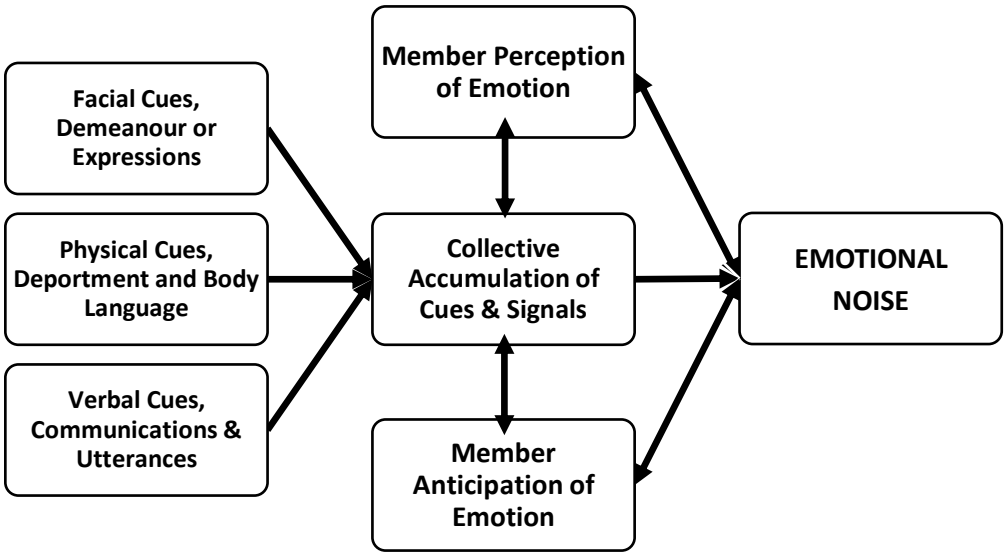
The fourth research theme concerns the need to comprehensively delineate the numerous possible interrelationships between each of the constructs within the model. It is not possible to list every one of these, so the point is best illustrated by means of an example. To explain, the case indicates that agents' reduced or depleted mental or cognitive resource has a role in the practice of inattentiveness. Less clear is whether there could be a role for it with deterrent practice. Similarly, the case indicates that misalignment between users' helping needs and organisational

helping resources could have a direct role in the practice of inattentiveness by directing agents' cognition away from users. It also suggests that there is an indirect role for this misalignment by means of its potential to deplete agents' cognitive resources more generally. However, once again it is less clear how this misalignment might affect indifferent practice. So, the model provides for the possibility of a far greater number of interrelationships than this study was capable of testing or determining. These offer a fruitful source of future research.

The last research theme concerns the concept of emotional noise. This requires further research to establish its validity as a concept. An investigation of its role in distracting organisational agents from users requires empirical confirmation. It could have been a simultaneous, but extraneous factor rather than a causal one in the inhibition of altruism. Exploration of the role of external institutions in contributing to emotional noise inside organisations would also be valuable. Since the study was not designed to investigate the concept, its properties have not been considered in detail. However, it is proposed here that it is comprised of: the collective accumulation of organisational members' emotional cues and signals; their extensive cognitive or affective perception or awareness of other members' pain and suffering; and their conscious or unconscious anticipation of distress amongst organisational members, in recognition of their condition. Emotional noise is therefore conceptualised as the collective accumulation of distressed signals, combined with the widespread perception or anticipation of member distress inside an organisation (see Figure 22 on the next page). This hypothesis requires empirical testing.

Brown, Rutherford and Crawford (2015) conceptualise clinical environments as having their own particular 'soundscape', which include technical and human factors, as well as daily rhythms, rather than being simply noisy. They suggest this raises questions about how such sounds are heard or interpreted. Arguably, responding to that question, a hospital soundscape might be interpreted as having an emotional tone, timbre or pitch which is cognitively and affectively discernible.

Figure 22: The Creation of Emotional Noise



Along these lines, many sounds within a hospital setting can be said to have an affective quality or property which constitutes, or contributes to, emotional noise. However the concept of emotional noise is considered to be broader in scope. It assumes that perceived or anticipated pain, suffering and distress will also have an emotional resonance or reverberation in the mind of the observer. So, even when no distress signals are emitted, nor is any pain and suffering visually or aurally communicated, agents might still anticipate emotional distress as a result of the internal organisational terrain or members' personal circumstances, especially where the latter are clearly and evidently adverse.

Some parallels with other constructs of 'noise' might be drawn. These can be found in the literature concerning the influence of sensory overload on altruism. Such perspectives contend that stimulus overload affects altruism by means of their influence on the extent to which needs are noticed (Shroeder et al., 1995). There is a clear body of evidence that potentially sensorily overwhelming or overloading factors can have a negative influence on responsiveness to others inside organisations or other busy environments (Sherrod and Downs, 1974, Mathews and

Canon, 1975; Cohen, 1980; Cohen and Spacapan, 1984). Critically, this can provoke attentional shifts away from social signals present within a situation (Jones, Chapman and Auburn, 1981; Stansfeld, Haines and Brown; 2000). It also leads to adaptive behaviours which reduce attentiveness and increase unhelpfulness (Milgram, 1970, Kortes, 1981). These patterns were evident in the case. It is a leap to argue that emotional noise has a similar effect to visual or aural forms of sensory overload, but it might well sit alongside such concepts. Though such studies have not considered the concept of overload as an affective property of organisational life in this way, the same distractions they offer are anticipated in association with emotional noise. However this provides a significant question for future research.

Moving on from the subject of research, there are a number of specific cautions which should be taken in respect of this study. One significant limitation of the study arises out of the nature of the design. This is a theoretical study rather than an empirical one, based on a single case. It is intended to develop and expand theory rather than confirm specific hypotheses. This is the most significant limitation, constraining the nature of conclusions. Importantly, many of the patterns which emerge from the data are compared and contrasted to develop theoretical propositions. They appear to correlate but such relationships have not been empirically tested and require replication. Moreover, given this design, causality between concepts, though plausible at times, cannot necessarily be determined from the data. It may be hypothetical supposition. Another weakness is that the patterns identified in the data tend to be behavioural. The author can speculate on motivations which might underpin such behaviour, using the ascriptions or constructions witnesses make, but this is still conjectural. By way of example, angry behaviour depicted in the data may be fuelled by moral frustrations (which is at times concluded) or by other emotions, such as personal shame, which are harder to ascertain. That said, it is especially relevant when studying altruism in organisational settings to focus on altruistic behaviours (that can be observed) regardless of motivation since it is the promotion of altruism which management

needs to understand and encourage regardless of impetus (Li, Kirkman and Porter, 2014).

A second limitation of this work concerns some challenges which were precipitated by the nature, volume and quality of the data. In this case the sheer volume of data was significant. Each of the two inquiries produced three volumes (of up to 1,000 pages). In addition, there were witness statements, summaries of oral evidence, expert reports and so on. Simply reading and coding the material available was a substantial challenge. Coding (and recoding) all the material from the inquiries would have been prohibitive. For this reason, some selective sampling was applied to witness statements produced for the public inquiry. Limiting the data coded in this way raises the prospect that some themes were over or under-presented, or even missed. This is potentially a theoretical limitation of the study. Whilst the quality of the data did not, on the whole, pose any theoretical problems for the study, it did create some technical limitations. Some of the material which was selected was subject to a small amount of data corruption. By way of example, some statements were written on or even scrambled. Such documents could not be coded using the software because of this. That meant that although they could be read, they could not be incorporated into the data tables which were used for analysis. Another problem with quality of the material was the potential for duplication. Given that there were two inquiries, certain events appeared more than once in the data. As a consequence, some themes may be over-represented from being reported more than once. That said, textual references to the same event often showed remarkable consistency. A final technical problem with the data is that the inquiries omitted paragraph or page numbering for certain documents (summaries of oral evidence in particular). This creates a challenge for readers who might wish to replicate or interrogate the data in this study.

A third limitation of the study is the potential for bias in the data. Problematically, the witness data is to some extent dependent on those who came forward. Consequently, there is more material from relatives than other types of witness

(such as friends). This has theoretical implications. One must also acknowledge the potential for bias arising out of the profile of statements and the perspective of those providing them. This means there is a need to be cautious when analysing or drawing conclusions from witnesses' oral statements to the inquiry. There are, for example, more instances of distress in the data which are related directly by relatives than by patients. This is a reflection of the number of statements provided by this group. With all witnesses, however, there are potential issues of time-lapse, memory-loss and retrospective sense-making. One needs to be especially alive to the possibility that inquiry reports are sensemaking narratives which may tell a particular story that they seek to impose that upon others (Brown, 2004). While steps were taken to minimise the impact of this, it must be acknowledged that the effect cannot be completely eradicated and that this form of bias may remain despite the best efforts of the author.

Along related lines, there was also lot of cultural change in the period around issues such as candour, and the inquiry witnesses may be applying standards which emerged later in the timeline of the inquiry. So, there could be biases concerning the cultural shifts which took place during this time. The period being studied is care at Stafford Hospital from January 2005 to March 2009. The first (independent) inquiry was announced on 21 July 2009 and reported its conclusions on 24 February 2010. The second (public) inquiry was announced on 9 June 2010, began on November 2010, and reported its conclusions on 6 February 2013. So, witnesses were asked to make statements in writing or orally (in private for the first inquiry and in public for the second) about events which took place at some distance, were contested as to causes, emotionally charged and in the spotlight. That said, the vividness and clarity of witnesses' memories indicates a lucidity which to some extent counteracts arguments that criticism could be solely shaped by hindsight.

A fourth limitation of the study arises out of the potential problems inherent in analysing the data. Ensuring the comprehensive and consistent coding of such a large volume of material produced over a long period of time was challenging. To ensure

the coding process was as comprehensive as possible the data was coded twice. To ensure consistency the author used a coding tracker (of both emerging and literature codes) during the coding process together with a series of questions to keep the coding process on track. Spot-check codings (and re-codings) of key themes (throughout the process) were adopted to ascertain any areas where inconsistency might be creeping in. In addition, NVivo key words searches were used to identify any areas of potential under-coding in areas of critical thematic importance. Despite these precautions, given the potential for human error, it should be acknowledged that it is possible that the data could be under-coded, that some themes could be coded inconsistently and that codes could create unnecessary duplication.

Some specific residual problems from this limitation must be acknowledged. Firstly, a small number of codes, such as 'change' for example, emerged towards the end of the second coding. Along similar lines, humour (jokes, flippancy, laughter, sarcasm) emerged during the first coding, but the potential to sub-code it, was considered too late in the process to make that viable. This could have benefited the study. Secondly, a small number of specific codes proved hard to work with. In particular, distress, personal arousal or distress and negative mood (the first an emerging code and the second two from the literature) were hard to distinguish between in the data. To overcome this, analysis was combined where necessary. Similarly, whereas repercussions (an emerging code) was easy to code, sanctions and punishment (a somewhat similar code from the literature) was harder to code. However, this prompted analysis which indicated a difference between actual sanctioning and the anticipation of it.

9.3 Conclusion

Fotaki says that healthcare is driven by less rational forces or conscious dynamics than the commonly applied market forces models allow for and that ignoring them 'creates toxicity in organisations and corrupts the moral institutional fabric' (Fotaki, 2016, p.1). Along similar lines, Wills and Hahn (1991) argue that although

professional norms and healthcare policies expect helping behaviour as a given, it will be influenced by less rational forces. This case suggests that they may be right. Imagine walking down a noisy busy street in a hectic and bustling city. There is someone homeless sitting at the side of the pavement. If you let your eyes slide over them, you might not be pained by their situation. If you do not look, you do not have to feel. Alternatively, you could change the way you think or feel about them. If you take the view that It is their own fault, or that they might drink away the change that you give them, then they are not worthy of your help. If you can think less of them, then you will not have to think less of yourself for not appreciating their situation. Or you could rush by and avoid noticing much about them in the first place. If they do not fully cross your field of vision, you do not have to be faced with any of this. What this research shows is that a busy hospital can be just like a busy city and a noisy ward is just like a noisy street. Professionals may, even, at times, as a result of their own actions, be less likely to notice that help is needed, be too hurried to stop or look around and notice what help is needed, or even be committed to reducing their chances of noticing anything at all. Putting this more simply, they may just not want to see. And that is why altruism is needed.

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SECTION VI

10 INQUIRY REPORTS

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12 APPENDICES

12.1 Appendix 1: Case Sampling

CASE	INQUIRY	SECTOR	RELATIONSHIP	PRODUCTS	REGULATION
Bristol Royal Infirmary ***(children's heart surgery from 1984 to 1995)***	Public (Kennedy Report, 18 July 2001)	Public (Healthcare, Hospital)	Users (Patients)	Free Service	System Professional
Alder Hey Hospital ***(use of human tissue).***	Independent (Redfern Report (30 January 2001)	Public (Healthcare, Hospital)	Users (Patients)	Free Service	System Professional
Winterbourne View ***(abuse of patients)***	Department of Health Review (Report, 10 December 2012) (and criminal proceedings)	Private (Healthcare, Care Home)	Users (Patients) Customers	Paid Service	System Professional
Mid Staffordshire NHS Foundation Trust ***(patient care)***	Independent (Report 24 February 2010) Public (Francis Report, 6 February 2013)	Public (Healthcare, Hospital)	Users (Patients)	Free Service	System Professional
Vale of Leaven Hospital (*patient deaths)*	Public (The Vale of Leven Hospital Inquiry Report, November 2014)	Public (Healthcare, Hospital)	Users (Patients)	Free Service	System Professional
Furness General Hospital (or Morecambe Bay) ***(patient deaths from 2014 to 2013)***	Public (Morecambe Bay Investigation Report, date 2015	Public (Healthcare, Hospital)	Users (Patients) Customers	Free Service	System Professional
Liverpool Care Pathway	Independent Review (Neuberger, 2013)	Public (Healthcare, Hospital)	Users (Patients) Customers	Free Service	System Professional
Diocese of Ferns ***(child abuse)***	Public Inquiry (Ferns Report, 2005)	Voluntary (Religion, Church)	Users	Free service	
Archdiocese of Dublin ***(child abuse,)***	(Murphy Report, 29 November 2009)	Voluntary (Religion, Church)	Users	Free service	
The News of the World ***(press culture and ethics***	(Judicial) Public Inquiry (Leveson Report November 2012)	Private (Media, Newspaper)	Customers	Paid Product	Voluntary
Al-Sweady Inquiry ***(treatment of detainees)***	Al-Sweady Inquiry (launched 2009) Report (December 2014)	Public (Army)	Users	Free Service	

12.2 Appendix 2: Pilot Findings

CONSTRUCT	IN THIS CASE	FEATURES
Individual level personal arousal or distress	Acted as a promoter triggered by witness's responses to the pain, distress and suffering of others.	Patients or relatives generally experienced personal arousal or distress as a result of the pain, suffering and distress of other patients and relatives, prompting altruistic behaviour towards them. Employees' personal arousal was generally triggered by the distress of another employee. When patients and relatives observed pain, suffering and distress it also invoked their empathy, generating other-suffering and other-condemning emotions (e.g. compassion for those in pain, and anger at those who do not help them).
Individual level negative moods, states or affect	Acted as an inhibitor for employees.	There are a wide range of moods or states identifiable in the pilot group including: anger, shock and alarm; stress, frustration and irritation; apathy, gloom, cynicism and pessimism; and fear, worry and anxiety. The most common moods or emotions for employees were fear and anxiety. The most common for patients and relatives were anger and frustration, and anxiety and concern. However, in the pilot it was difficult to disentangle negative moods or emotions from the personal arousal or distress they caused.
Contextual costs (e.g. time, money, resources)	Acted as an inhibitor for employees.	Employees considered the environment to be one of significant time constraint, a factor which appears to have limited their capacity for altruistic acts. Patients and relatives were also sensitive to this and reinforced employees' own perceptions of themselves as operating under substantial time pressures.
Situational Contextual or Strength	Acted as an inhibitor for employees by impinging on their capacity for altruism.	One employee indicated that the situation exercised a strong and controlling influence over employees, through leadership, culture, resources (especially staffing levels), and systems, processes or routines for delivering care. Such situational factors appear to have distracted them from patients and reduced their level of discretionary effort, in effect inhibiting their altruism.
Contextual level social Influence or approval (& disapproval	Acted as an inhibitor for employees by impinging on their capacity for altruism.	One employee indicated that social disapproval may have exercised a controlling influence over employees. Again, this appears to have distracted employees from patients and reduced their level of discretionary effort, effectually inhibiting altruism.
Contextual job stressors	Acted as an Inhibitor for employees by impinging on their capacity for altruism.	Employees indicated a high level of job stress. There is a general sense of pressure and strain from their roles and workload. Such factors appear to have (in conjunction with other contextual and relational features) distracted them from patients and reduced discretionary effort, thereby inhibiting altruism.
Leadership supportiveness	Acted as an inhibitor for employees by being absent.	Employees indicated a substantial lack of support from leaders. There is a general sense of pressure and strain from managers' expectations and targets. Such factors appear to have (in conjunction with other contextual and relational features) distracted them from patients and reduced discretionary effort, thereby inhibiting altruism.

12.3 Appendix 3: Coding Template

1 : Case timeline, events and facts
2 : Emerging Behaviours
3 : Abandoning (or abandoned)
4 : Alone
5 : Dumping
6 : Forgotten
7 : Lost
8 : Abusing
9 : Accepting
10 : Aggressive (or aggression)
11 : Antagonistic (or antagonism)
12 : Friction
13 : Apologising
14 : Attentive (or paying attention)
15 : Avoiding
16 : Belittling
17 : Blaming
18 : Scapegoating
19 : Brusque
20 : Bullying
21 : Harassment
22 : Callousness
23 : Cruelty
24 : Insensitivity
25 : Comforting
26 : Complaining
27 : Concern (raising)
28 : Confidence (having faith in)
29 : Deferring (& deference)
30 : Demanding
31 : Deterring (or deterrents)
32 : Dignity (treating people with)
33 : Dismissing
34 : Brush off
35 : Fob off
36 : Engaged (or disengaged)
37 : Explaining
38 : Eye Contact
39 : Help seeking
40 : Helping
41 : Not helping or being helped (action or behaviour, context or state)
42 : Hostility
43 : Humour
44 : Ignoring
45 : Intimidating (or feeling intimidated)
46 : Kindness
47 : Labelling
48 : Listening
49 : Misconduct
50 : Malfeasance
51 : Mistakes
52 : Nasty
53 : Neglecting
54 : Noticing
55 : Panicking
56 : Patronising
57 : Perfunctorily
58 : Politeness
59 : Praising
60 : Impressed
61 : Professionalism
62 : Protecting
63 : Questioning
64 : Reassuring (or reassurance)
65 : Refusing
66 : Reprimanding
67 : Resisting
68 : Respecting
69 : Disdainful
70 : Responding
71 : Roughness
72 : Rudeness
73 : Scrutiny or scrutinising
74 : Secretive
75 : Shouting
76 : Silent (silencing or silenced)
77 : Speaking out
78 : Supporting or supportive
79 : Threatening (or feeling threatened)
80 : Trusting
81 : Un-noticing (or un-noticed)
82 : Unwelcoming
83 : Waiting
84 : Warning
85 : Whistleblowing
86 : Emerging Context
87 : Closed
88 : Conspiracy (or suspicion)
89 : Culture
90 : Deterioration
91 : Openness
92 : Transparent
93 : Uncomfortable
94 : Warning Signs
95 : Emerging emotions or feelings
96 : Caring
97 : Distress
98 : Upset
99 : Nostalgia
100 : Suffering
101 : Pain
102 : Emerging miscellaneous
103 : Individual Beliefs, Morals, Norms or Standards
104 : Beliefs
105 : Fairness
106 : Integrity
107 : Justice
108 : Other beliefs
109 : Morality
110 : Personal Norms or Standards
111 : Personal responsibility (or ascription of)

112 : Individual Moods, Emotions and Feelings, and Personal Arousal or Distress
113 : Defence Mechanisms
114 : Defensiveness
115 : Denial
116 : Dissociation
117 : Distortion
118 : Passive Aggression (Chair removal)
119 : Rationalisation
120 : Emotions (moral)
121 : Anger
122 : Compassion
123 : Contempt
124 : Disgust
125 : Elevation
126 : Embarrassment
127 : Gratitude
128 : Guilt
129 : Shame
130 : Sympathy
131 : Unsympathetic
132 : Emotions (non-moral)
133 : Anxiety
134 : Apathy
135 : Indifference
136 : Uncaring
137 : Cheerfullness
138 : Despair
139 : Dismay
140 : Fear
141 : Dread
142 : Frustration
143 : Grief
144 : Happiness
145 : Helplessness
146 : Hope
147 : Horror
148 : Humiliation
149 : Irritation
150 : Annoyance
151 : Overwhelmed (emotion)
152 : Pride
153 : Resentment
154 : Sadness
155 : Shock
156 : Alarm
157 : Stress
158 : Surprise
159 : Vengefulness
160 : Vulnerability
161 : Worry (or concern)
162 : Empathy
163 : Negative mood
164 : Temper
165 : Over-arousal Effect
166 : Personal Arousal or Distress
167 : Uneasy (ill at ease)
168 : Positive mood

169 : Individual Personality or Characteristics
170 : Altruistic Personality
171 : Conformity
172 : Non-Conformity
173 : Personal Characteristics
174 : Agreeableness (A)
175 : Approachable
176 : Considerate
177 : Friendly
178 : Helpful
179 : Patient
180 : Pleasant
181 : Conscientiousness (C)
182 : Dedicated
183 : Hardworking
184 : Lazy
185 : Emotionality (E)
186 : Extraversion (X)
187 : Honesty-Humility (H)
188 : Arrogant
189 : Loyal
190 : Openness to Experience (O)
191 : Personal Efficacy
192 : Competence
193 : Internal Control (Locus of)
194 : Self-Esteem
195 : Internal document, report or correspondence
196 : Negative
197 : Organisational Factors
198 : Felt Concern (Organisation)
199 : Felt Obligation (Organisation)
200 : Group Cohesiveness (Organisation)
201 : Teamwork
202 : Group Membership (Organisational)
203 : Job Satisfaction (or dissatisfaction)
204 : Job Stressors (Organisation)
205 : Burnout
206 : Busy
207 : Exhaustion
208 : Insecurity (of employment)
209 : Overworked
210 : Pressure
211 : Rushing
212 : Leadership Supportiveness
213 : Organisational supportiveness
214 : Organisational Metaphors
215 : Change (Organisation)
216 : Culture (Organisation)
217 : Information (Organisation)
218 : Instrument of Domination (Organisation)
219 : Machine (Organisation)
220 : Organism (Organisation)
221 : Political System (Organisation)
222 : Psychic Prison (Organisation)
223 : Organisational Pro Social Behaviours (13)
224 : 01. Assisting co-workers with job-related matters
225 : 02. Assisting co-workers with personal matters.

226 : 03. Showing leniency in personnel decisions.
227 : 04. Providing services or products to consumers in organisationally consistent ways
228 : 05. Providing services or products to consumers in organizationally inconsistent ways.
229 : 06. Helping consumers with personal matters unrelated to organizational services or products
230 : 07. Complying with organizational values, policies, and regulations.
231 : 08. Suggesting procedural, administrative, or organizational improvements.
232 : 09. Objecting to improper directives, procedures or policies
233 : 10. Putting forth extra effort on the job
234 : 11. Volunteering for additional assignments.
235 : 12. Staying with the organization despite temporary hardships.
236 : 13. Representing the organisation favourably to outsiders
237 : Other Healthcare Institution (inc Cannock)
238 : Positive
239 : Quotes
240 : Relational - General Reciprocal Principles or Relations
241 : Indirect Reciprocity
242 : Reputation
243 : Reciprocal Altruism
244 : Patient as carer
245 : Strong Reciprocity
246 : Relational - Kin or Kinship
247 : Relational - Social Roles, Rules, Relations and Structures
248 : Groups
249 : Observers or Third Parties
250 : Punishment or Sanctions
251 : Social Norms
252 : Social Roles
253 : Friendship
254 : Social Traps or Fences
255 : Role (perspective)
256 : Board Member
257 : Doctor
258 : Friend
259 : Manager
260 : Nurse
261 : Other Employee
262 : Other role
263 : Patient
264 : Regulator
265 : Relative
266 : Senior Executive
267 : Situational (contextual) Costs and Rewards or Other Expectations
268 : Costs
269 : Ostracising
270 : Rewards
271 : Roles or Responsibilities
272 : Rules, Processes or Systems
273 : Admittance

274 : Care (& treatment)
275 : Care (action or behaviour inc. basic care, caring)
276 : Treatment (or Service)
277 : Complaints, incidents & events
278 : Diagnostics
279 : Discharge (& external transfers)
280 : Drugs (& medication)
281 : Food (& hydration)
282 : Information (& communication)
283 : Buzzers
284 : Communication
285 : False
286 : Information
287 : Knowledge
288 : Record-keeping (&records)
289 : Monitoring
290 : Personal hygiene (& toilet assistance)
291 : Resuscitation
292 : Targets
293 : Ward moves (& internal transfers)
294 : Situational (or contextual) Participants
295 : Audience Inhibition
296 : Dehumanisation
297 : Derogation
298 : Deindividuation
299 : Diffusion of Responsibility (Bystander Effect)
300 : Humanisation
301 : Recipient Characteristics
302 : Dementia
303 : Dependency
304 : Inconvenience
305 : Nuisance
306 : Elderly
307 : Likable
308 : Vulnerability
309 : Social influence (approval or disapproval)
310 : Situational (or contextual) Strength
311 : Chaos
312 : Conflict of Interest
313 : Confusion
314 : Disorientation (context or state)
315 : Death
316 : Bereavement
317 : Delay
318 : Disaster
319 : Isolation
320 : Power
321 : Repercussions
322 : Resources
323 : Equipment
324 : Time
325 : Visibility
326 : Staff
327 : Junior staff (quality or characteristic)
328 : Leadership
329 : Management
330 : Senior staff (quality or chracateristic)
331 : Staff attitude (quality or characteristic)

332 : Staff availability (context or state)
333 : Staff competence (quality or characteristic)
334 : Staff experience (quality or characteristic)
335 : Staff levels (context or state)
336 : Staff morale (emotion)
337 : Staff sickness (incident or event)
338 : Staff training (incident or event)
339 : Staff turnover (incident or event)

340 : Tier
341 : Executive
342 : Expert
343 : External Individual
344 : External Organisation
345 : Inquiry
346 : Non-Executive
347 : Professional

12.4 Appendix 4: Literature Review Process

In view of the commitment to an iterative approach, the literature review is organised in various phases. The purpose of the first phase was to familiarise the researcher with the concept of altruism and develop an initial feel for the scale and scope of the literature. The first phase (See Table A below) showed that the most pertinent disciplines for the study would be management, business, economics, social psychology, sociology, behavioural science, anthropology, evolutionary biology, social sciences, philosophy, political science and ethics.

Table A: Phase One Literature Review

ACTION	ENGINE	TERMS	PARAMETERS	OUTPUT
Search	Web of Knowledge	altruism, kindness, empathy sympathy, compassion, prosocial or prosocial behaviours	all years (articles, books, papers, letters and other material).	57,345 items
Search	Web of Knowledge	organisational failure, critical incidents	all years (articles, books, papers, letters and other material)	14,770 items
Review	Web of Knowledge	"altruism"	all years (500 most highly cited papers)	management, business, economics, social psychology, sociology, behavioural science, anthropology, evolutionary biology, social sciences, philosophy, political science, ethics

The purpose of the second phase (See Table B below) was to identify ways in which to refine the search scope to a more manageable level. This included a second narrower search for the 500 most cited papers (one for management on its own, and one for all disciplines together), which when combined identified a total of 89 papers

for review and 180 for possible review. Phases one and two produced some key constructs (which are set out in Appendix Two).

Table B: Phase Two Literature Review

ACTION	ENGINE	TERMS	PARAMETERS	OUTPUT
Search	Web of Science	altruism, kindness, compassion, prosocial [275]	Years 1945-2013 (for articles, books, book chapters, reviews and proceedings in English) in above disciplines.	4,069 items
Review (Top 500 abstracts)	Web of Science	Same	Same parameters, same disciplines	35 papers for probable review and 124 for possible review.
Review (Top 500 abstracts)	Web of Science	Same	Same parameters, management discipline alone	54 papers for probable review and 56 for possible review.
Search	Web of Science	Same plus nurses or nursing	Years 1945-2013 (for articles, books, book chapters, reviews and proceedings in English) in above disciplines.	27 papers for probable review and 19 for possible review.

Phase two showed that papers are likely to be especially relevant if they are a classic citation paper, a landmark paper for other reasons (i.e. ground-breaking in the field), or have an organisational application or setting. It also showed that a large number of papers are likely to be irrelevant, particularly those relating to: non-human altruism (insects or animals); human genetic factors; corporate social responsibility; charitable giving; philanthropy or volunteering; and spiritual practises (e.g. mindfulness or loving-kindness meditation). In addition, a small discrete search, in field of nursing, identified the potential relevance of searching professional groupings related to case industry. Both these phases demonstrated the scale of the

[275] Incorporates the following: Science Citation Index Expanded (1945-present), Social Sciences Citation Index (1970-present), Arts & Humanities Citation Index (1975-present), Conference Proceedings Citation Index- Science (1990-present), Conference Proceedings Citation Index- Social Science & Humanities (1990-present), Book Citation Index– Science (2005-present), Book Citation Index– Social Sciences & Humanities (2005-present).

literature, and the need for tighter search parameters to make the review manageable and organisationally pertinent.

A third literature review was undertaken alongside the pilot study to assist with the development of a core set of constructs. This yielded 378 articles, of which all were reviewed at abstract level and an additional 53 articles were reviewed in full (see Table C below). These were used to finalise the key constructs for the Predetermined Codes.

Table C: Phase Three Literature Review

ACTION	ENGINE	TERMS	PARAMETERS	OUTPUT
Search	Web of Science	altruism OR altruistic OR prosocial; AND organisations or organisational; AND human (to exclude the large amount of material on non-human groups)	Years 1976-2016 (for articles, books, book chapters, and reviews in English) Additional exclusion parameters were: child* OR adolescen* and philanthop* OR charit* OR volunteer*.	378 items (reviewed at abstract level) 53 articles reviewed in full

12.5 Appendix 5a: Code Summary

CORE THEMES	ORGANISATIONAL NARRATIVES
AN EMOTIONALLY NOISY ORGANISATION	**High Need Narrative**: An organisational user group with a high level of need and dependency.
	High Distress Narrative: A high level of pain, suffering and distress amongst organisational members.
	High Uncertainty Narrative: An organisational context which is chaotic, insecure and uncertain.
A CLIMATE OF CONFLICT BETWEEN ORGANISATIONAL MEMBERS	**Threatening Narrative:** a threatening and unwelcoming organisational culture.
	Conflict Narrative: a high level of friction between organisational members.
	Diminishment Narrative: The derogation or 'diminishment' of organisational members.
A DEMANDING AND DEPLETING ORGANISATIONAL CONTEXT	**High Strain Narrative:** a high internal load on organisational agents.
	Low support Narrative: a low level of support for organisational agents including insufficient resource and constraining or inflexible organisational systems or routines.
UNRESPONSIVE ORGANISATIONAL AGENTS	**Inattentive Practices:** Organisational agents' inattentiveness towards users.
	Indifferent, Uncompassionate or Unfeeling Practices: Organisational agents' indifference towards users
	Avoidant Practices: Organisational agents' avoidance of organisational users.
	Deterrent Practices: Organisational agents' deterrence of organisational users from approaching them.

12.6 Appendix 5b: Complete Code Amalgamation

The full set of codes and their allocation is shown below. Some codes are duplicated across groups, and 13 codes have not been loaded onto the model.

THEME ONE - EMOTIONAL NOISE		
SUB THEMES (SECOND ORDER)	**CODE GROUPINGS (THIRD ORDER)**	**INDIVIDUAL CODES (FOURTH ORDER)**
High 'need' vulnerable organisational users	• Vulnerable organisational users.	• *Elderly* • *Dementia*
	• Dependent organisational users.	• *Alone* • *Dependency* • *Vulnerability* • *Helplessness* • *Uncomfortable*
	• Demanding organisational users with significant needs and/or expectations.	• *Pain, Suffering* • *Personal Arousal or Distress* • *Help-seeking, Helplessness* • *Vulnerability, Dependency* • *Fear, Anxiety, Worry (or Concern)* • *Dread, Horror* • *Shock, Alarm, Surprise* • *Visibility (N)* • *Relational - Kin or Kinship* • *Patient as carer* • *Helping, Protecting* • *Demanding, Questioning, Scrutiny (or scrutinising)* • *Likeable (N)*
Organisational members' pain, suffering and distress.	• Distressed (and in need) organisational users.	• *Pain, Suffering* • *Upset, Distress* • *Personal Arousal or Distress* • *Uneasy (ill at ease)* • *Deterioration, Death, Bereavement, Hope, Grief*
	• Concern for (or on behalf of) organisational members	• *Empathy, Compassion, or Sympathy* • *Worry (or concern), Concern (raising).* • *KIndness*
	• Strong moods , states or or emotions	• *Anger Contempt, Disgust* • *Shame, Guilt, Embarrassment* • *Fear, Worry (or concern), Anxiety* • *Sadness, Dismay, Despair* • *Dread, Horror* • *Shock, Alarm, Surprise* • *Over-arousal effect*
Organisational chaos and uncertainty.	• Unclear and uncertain events or situations	• *Chaos, Disaster* • *Confusion, Disorientation* • *Delay, Waiting* • *Reassuring (or reassurance) (N)* • *Explaining (N)* • *Audience Inhibition*
	• Overlooked and disregarded users.	• *Lost, Forgotten* • *Dumping, Abandoning*
THEME TWO - CONFLICT CLIMATE		

SUB THEMES (SECOND ORDER)	CODE GROUPINGS (THIRD ORDER)	INDIVIDUAL CODES (FOURTH ORDER)
A strong, closed, inescapable situation.	A closed and isolated situation.	• *Closed, Isolation* • *Openness (N), Transparent (N)* • *Secretive, Conspiracy (or suspicion)* • *Situational or contextual strength* • *Warning signs* • *Staying with the organization despite temporary hardships.*
	A strong and suppressive context.	• *Silent (silencing or silenced)* • *Speaking out (N), Whistleblowing* • *Situational or contextual strength* • *Warning signs* • *Negative mood*
A threatening and unwelcoming culture.	An unwelcoming organisational culture.	• *Culture* • *Deterring (or being deterred)* • *Dismissing, brush off, fob off* • *Brusque, Politeness (N)* • *Unwelcoming, Perfunctorily* • *Staff (attitude) (N)*
	A threatening organisational culture.	• *Culture* • *Bullying, Harassment,* • *Intimidating (or feeling intimidated)* • *Threatening (or feeling threatened),* • *Job stressors (insecurity of employment* • *Change (organisation)* • *Culture (organisation)* • *Instrument of Domination (Organisation)* • *Complying with organizational values, policies, and regulations.* • *Objecting to improper directives, procedures or policies*
	The expectation of repercussions or retaliation.	• *Power* • *Resisting* • *Repercussions* • *Blaming, Scapegoating, Reprimanding* • *Vengefulness* • *Psychic Prison (Organisation)* • *Political System (Organisation)*
Hostility and aggression between organisational members.	Friction between organisational members .	• *Friction* • *Hostility, Aggressive (or aggression), Antagonistic (or antagonism)* • *Frustration, Irritation, Annoyance, Temper* • *Abusing, Rudeness,* • *Nasty.* • *Conflict of Interest*
	Criticism of others (and other-condemning or self-praising emotions)	• *Anger, Contempt, Disgust* • *Complaints, incidents & events (N), Complaining, Concern (raising)* • *Ostracising* • *Pride*
	Self-criticism and self-condemning emotions	• *Shame, Guilt, Embarrassment*
The diminishment of others.	The dehumanisation of organisational users.	• *Dehumanisation, Humanisation* • *Derogation, Labelling* • *Callousness, Cruelty* • *Insensitivity, Humour (N)* • *Staff (attitude) (N)* • *Machine (Organisation)*

	The disrespectful or undignified treatment of organisational members.	• *Dignity (N)* • *Disdainful, Respecting (N)* • *Inconvenience, Nuisance* • *Roughness*, *Brusque* • *Belittling*, *Patronising*, • *Insensitivity, Humour (N)* • *Derogation*, *Labelling* • *Callousness, Cruelty, Humiliation*
DEMANDING AND DEPLETING WORK		
SUB THEMES (SECOND ORDER)	**CODE GROUPINGS (THIRD ORDER)**	**INDIVIDUAL CODES (FOURTH ORDER)**
High-load on organisational agents.	Organisational agents are physically overloaded or temporally overstretched, and/or lack sufficient physical or temporal resources. ***(Physically overloaded and Temporally overstretched)***	• *Pressure, Stress* • *Busy, Rushing* • *Overworked*, *Hardworking*, *Lazy* • *Exhaustion*, *Burnout* • *Putting forth extra effort on the job (N)* • *Volunteering for additional assignments. (N)*
	Organisational agents are mentally overtaxed and/or lack sufficient cognitive resources. (***Mentally overtaxed)***	• *Personal efficacy, Competence,* • *Internal Control (locus of), Self-esteem* • *Beliefs (fairness, integrity, justice, other)* • *Morality* • *Personal Norms or Standards)* • *Personal responsibility (or ascription of)* • *Openness to Experience (O)*
	Organisational agents are emotionally overwhelmed and /or lack sufficient affective resources. **(Emotionally Overwhelmed)**	• *Empathy, Compassion, or Sympathy* • *Uncaring, Caring (N),* • *Panicking, Shouting,* Crying • *Overwhelmed, Over-arousal effect* • Detachment*, Apathy, Indifference*
	Demanding organisational users with significant needs and/or expectations.	• *Pain, Suffering* • *Personal Arousal or Distress* • *Help-seeking, Helplessness* • *Vulnerability, Dependency* • *Fear, Anxiety, Worry (or Concern)* • *Dread, Horror* • *Shock, Alarm, Surprise* • *Visibility (N)* • *Relational - Kin or Kinship* • *Patient as carer* • *Helping, Protecting* • *Demanding, Questioning, Scrutiny (or scrutinising)* • *Likeable (N)*
Low support for organisational agents.	Low levels of relational support for organisational agents.***(Relationally under supported)***	• *Leadership (N), Management (N)* • *Leadership Supportiveness (N)* • *Organisational Supportiveness (N)* • *Costs, Rewards (N)* • *Punishment or Sanctions* • *Social Norms* • *Labelling*, *Ostracising* • *Supporting, Supportive (N)* • *Assisting co-workers with job-related matters* • *Assisting co-workers with personal matters.* • *Showing leniency in personnel decisions.*

	High levels of cultural pressure on organisational agents. (***Culturally under supported)***	• Time, *Rushing*, *Pressure* • *Costs, Rewards (N)* • *Punishment or Sanctions* • *Social Norms* • *Targets*
Low levels of organisational resource.	• Insufficient Physical Resources • Insufficient Temporal Resource. • Insufficient Mental Or Emotional Resources.	• *Resources, Equipment* • *Staff Levels (N)* • *Staff Availability (N),* • *Staff Competence (P/N),* • *Staff Experience (N)* • *Staff Morale (N)* • *Staff Sickness (N)* • *Staff Training (N)* • *Staff Turnover(N)* • *Junior Staff (N)* • *Senior Staff (N)* • *Time, Rushing, Pressure* • *Job Satisfaction (or dissatisfaction)* • *Agreeableness (N) (Approachable, considerate, Friendly, Helpful, Pleasant)* • *Conscientiousness (N) (Dedicated, Hardworking, Lazy)* • *Emotionality* • *Extraversion (X)* • *Honesty-Humility (H) (Arrogant, Loyal)* • *Openness to Experience*
Constraining Organisational Architecture.	Social and Structural roles or relationships	• *Roles or Responsibilities* • *Role (perspective) (Board Member, Doctor, Friend, Manager, Nurse, Other Employee, Other Role, Patient, Regulator, Relative, Senior Executive)* • *Tier (Executive, Expert, External Individual, External Organisation, Inquiry, Non-Executive, Professional)* • *Deindividuation* • *Reputation* • *Diffusion of Responsibility (Bystander Effect)* • *Groups, Group Cohesiveness, Group Membership* • *Teamwork* • *Observers or Third Parties* • *Social Roles* • *Friendship* • *Relational - Kin or Kinship* • *Reputation*
	Unresponsive or unsupportive Rules, Processes and Systems	• *Admittance, Discharge, Ward Moves* • *Diagnostics, Care (& Treatment)* • *Complaints, Incidents and Events* • *Food (& hydration)* • *Drugs (& medication)* • *Information (& Communication) (Buzzers, Communication, False, Information, Knowledge, Record-Keeping & Records)* • *Monitoring* • *Personal hygiene (& toilet assistance)* • *Resuscitation* • *Information (Organisation)* • *Providing services or products to consumers in organisationally consistent ways* • *Providing services or products to consumers in organizationally inconsistent ways.*

		• *Helping consumers with personal matters unrelated to organizational services or products*
	Structural norms and expectations.	• *Deindividuation* • *Indirect Reciprocity* • *Reciprocal Altruism* • *Social influence (approval or disapproval)* • *Social Traps or Fences* • *Nostalgia* • *Felt Concern (Organisation)* • *Felt Obligation (organisation)* • *Gratitude* • *Suggesting procedural, administrative, or organizational improvements.(N)* • *Representing the organisation favourably to outsiders*
UNRESPONSIVENESS		
SUB THEMES (SECOND ORDER)	**CODE GROUPINGS THIRD ORDER**	**CODES**
Detached Organisational Agents	1. Not seeing/ (Un-noticing (or un-noticed)	• *Noticing (N)* • *Un-noticing (or un-noticed)* • *Attentive (or paying attention) (N*) • *Ignoring* • *Listening* (N), • *Eye contact* (N)
	2. Not feeling, unfeeling or uncaring	• *Compassion (N), Unsympathetic* • *Uncaring, Caring (N),* • *Comforting (N), Reassuring (or reassurance) (N), Explaining (N)* • *Apathy, Indifference*
Unresponsive Organisational Agents	3. Not responding or unresponsiveness	• *Neglecting* • *Responding* (N) • *Engaged or Disengaged* • *Helping, Not helping or being helped* • *Comforting* (N) • *Refusing* • *Professionalism (N)*
	4. Defending or acting defensively	• *Defence Mechanisms, Defensiveness* • *Denial, Distortion, Dissociation* • *Rationalisation* • *Passive Aggression, Resentment* • *Apologising (N), Accepting (N)* • *Avoiding, Deferring (& deference)* • *Misconduct, Malfeasance, Mistakes*

12.7 Appendix 6: Data Output Samples

Data Table Type 1: Code (by role)

In this type of table, codes are shown by the role (or perspective) of witnesses, to identify which groups most commonly identify issues. Where possible, any themes which arise from analysis of the raw text will be identified and illustrated with sample quotes in the analysis.

The example for nostalgia shown below suggests that this is a small theme mainly raised by patients or relatives. Analysis of the raw text suggests that members of this group may hark back to days when the healthcare system itself was run very differently.

Table Nostalgia

ROLE CODES	REFERENCES
1 : Board Member	0
2 : Doctor	4
3 : Friend	0
4 : Manager	0
5 : Nurse	0
6 : Other Employee	1
7 : Other role	0
8 : Patient	9
9 : Regulator	0
10 : Relative	7
11 : Senior Executive	0

An alternative example coded for anger (below) indicates that this emotion is most commonly exhibited by relatives. Relatives are the main group to significantly indicate or express this emotion. Analysis of the raw text suggests that (for this group) anger is generally precipitated by the treatment of family members or (inadequate) responses to their complaints about that treatment. Interestingly, there is also a small amount of evidence of professionals' anger being precipitated by (and/or perceived as directed at) patients themselves, their needs and demands.

Table Anger (by role)

ROLE CODES	REFERENCES
1 : Board Member	3
2 : Doctor	3
3 : Friend	1
4 : Manager	0
5 : Nurse	5
6 : Other Employee	1
7 : Other role	2
8 : Patient	2
9 : Regulator	0
10 : Relative	28
11 : Senior Executive	3

Data Table Type 2: Positive versus Negative Patterns

In this type of table, codes are shown alongside positive and negative codes to see which they are most often co-coded against. The example below for fear shows the emotion to be unsurprisingly negative.

Table Fear (positive versus negative)

FEAR CODES	NEGATIVE	POSITIVE
1 : Fear	102	6
2 : Dread	1	0

An alternative example below which codes arousal (and related concepts) indicates that feeling aroused or distressed was also generally experienced as a negative event.

Table Arousal (positive versus negative)

AROUSAL CODES	NEGATIVE	POSITIVE
1 : Distress	125	6
2 : Upset	41	3
3 : Anxiety	16	2
4 : Worry (or concern)	106	11
5 : Negative mood	63	2
7 : Over-arousal Effect	32	0
8 : Personal Arousal or Distress	186	14

Data Table Type Three: Code (all other Codes)

In this type of table, a code is shown against all other codes. This data is used to assist with the production of the other tables.

Table: Fear (cross referenced for all codes) - Excerpt

ALL OTHER CODES	FEAR
65 : Care (basic care, caring)	3
66 : Caring (showing care, caring, etc)	0
67 : Uncaring (inc. care less, care lack)	0
68 : Chaotic (inc chaos, hectic, disorganised)	0
69 : Closed	0
70 : Comforting (comfort, comforted)	0
71 : Communication	0
72 : Complaints (make complaint, complained, complaining)	11
73 : Concern (raising concerns)	3
74 : Confidence	0
75 : Conflict of Interest	0
76 : Confused (inc confuse, confusing, unclear, lack of clarity)	1
77 : Considerate (inc. consideration)	0
78 : Conspiracy (inc. cover up, whitewash)	0
79 : Cruel (inc cruelty)	0
80 : Culture	7
81 : Death	0
82 : Dedicated	0
83 : Defensive	0
84 : Delay	0
85 : Demanding	0
86 : Denial	0
87 : Derogation	0
88 : Deterioration	0
89 : Dignity	0
90 : Disaster	0
91 : Disdainful (inc disdain)	0
92 : Dismissive	0
93 : Disorientated	0
94 : Dissociation	0
95 : Distancing (inc distant, detached, removed, etc)	0
96 : Dumping (inc dumped, dumping ground)	0
97 : Equipment	1
98 : Exhausted	0
99 : Explaining	1
100 : Eye Contact (looking)	0
101 : Fairness	0
102 : False (or falsified)	2
103 : Fobbed Off	0
104 : Forgotten (inc. left, lost)	0
105 : Friction	3
106 : Friendliness	0
107 : Friends or Friendship	0

Data Table Type 4: Code Conjunctions

In this type of table, codes are shown alongside other codes against which they are most often co-coded.

The example below using fear indicates that it could be an issue for staff which is associated with employment related matters (e.g. organisational culture, job related stressors, job security). This example also suggests that fear might inhibit complaints, with potential cultural restraint and concern about retaliation. Separate analysis of the raw text for job security (and job or employment related stressors) and complaints (or raising concerns) confirmed these themes.

Table Fear (most Common Code Conjunctions)

CODES	REFS
183 : Staff	13
72: Complaints (make complaint, complained, complaining)	11
80 : Culture	7
128 : Job security (inc. job loss, insecurity)	7
170 : Repercussions (retaliation)	7
270 : Personal Arousal or Personal Distress	7
290 : Job or Employment Related Stressors	7
241 : Negative Mood, State or Affect, Negative State Relief, Arousal Reduction	6
187 : Staff (levels)	4
196 : Targets	4
229 : Anger	4
267 : Vulnerability	4
299 : Organisation as Instrument of Domination	4

An alternative example below for compassion shows that compassion is not a singularly negative factor. Although compassion is most likely to appear with a negative coding, it also appears in conjunction with a positive coding (43 negative references compared to 22 positive refences), suggesting that compassion is not a solely negative feature (i.e. absent, or lacking) in this case. Of the other most frequently coded together with compassion, the most notable is staff attitude with 21 conjunctions in the coding. The next most common conjunctions are a group of

codes which congregate around caring emotions, actions or behaviours, and professionalism. Other interesting conjunctions are death and communications.

Table Compassion (most Common Code Conjunctions)

COMMON CONJUNCTIONS	COMPASSION	SYMPATHY	EMPATHY
195 : Negative	43	22	10
237 : Positive	22	11	11
329 : Staff attitude (quality or characteristic)	21	4	5
95 : Caring	8	0	2
129 : Sympathy	6	34	1
282 : Communication	6	0	0
313 : Death	6	0	1
273 : Care (action or behaviour inc. basic care)	5	1	2
60 : Professionalism	5	0	1
25 : Complaining	5	6	2
39 : Helping	4	0	3
58 : Praising	4	2	3
161 : Empathy	4	1	25
284 : Information	4	0	0

Data Table Type Five: Raw Text (by theme or conjoined themes)

In this type of table, the raw data (from inquiry reports, witness statements and so on) which has been coded is captured for analysis.

Sample pages of the data exports for fear and fear and complaining together is shown below. This data confirms fear as a possible obstacle to complaining.

FEAR AND COMPLAINING CODES TEXTUAL DATA SAMPLE PAGE
Internals\\Employee 11 Whilst the whistleblowing policy is in place, I still think there was, and is, a reluctance to raise concerns. I think there was a culture of fear to speak up, as it is difficult to talk about colleagues in a critical way. In an organisation where employees work and live in the same place it is often easier if complaints and concerns are raised externally. This culture of fear was reinforced with the workforce reductions. Internals\\Employee 13

Despite complaints from nurses and patients increasing, and sickness levels for staff going through the roof, nurses were afraid to complain.

Internals\\Employee 23

At this point the floodgates opened and a lot of other people came forward to complain about the poor practice and bullying culture in A&E. However, the climate of fear still existed and so many people did so anonymously. They agreed with everything I was saying but could see what was happening to me and often backed down. The way that I was treated put many people off raising their heads above the parapet.

Internals\\Independent Inquiry Report-Vol1 (2010)

patients' attitudes were characterised by a reluctance to insist on receiving basic care or medication for fear of upsetting staff.

Internals\\Independent Inquiry Report-Vol2 (2010)

I was frightened to complain in case my treatment got even worse

Internals\\Independent Inquiry SUMMARYOFORALEVIDENCEWEEK2

He also recalls experiences of bullying by one member of staff on Ward 11. Mr D1 did not complain about this at the time because he felt vulnerable and feared repercussions.

Internals\\Relative 09

was never happy with the treatment that she received from Stafford Hospital, but she did not want us to complain when she was admitted to the hospital because she said that the staff would take it out on her and she feared retaliation.

Internals\\Relative 15

Meanwhile, was afraid to complain about anything because he thought that if he did he might make his stay there even more uncomfortable.

Internals\\Relative 20

1 [sic] know that one night he was lying in a wet bed for hours, and it had got to the stage that he was too frightened to complain in case they took it out on him.

He got agitated, saying things like "Oh, what have you done, don't complain, they'll take it out on me."

12.8 Appendix 7: Coding Tracker Excerpt

FIRST CODING	SECOND	CONSTRUCT AIDS
Empathy, empathetic concern (altruistic emotions such a compassion, concern, warmth, softheartedness), empathetic arousal, empathetic distress	Empathy	• 'ability to understand and appreciate another person's feelings, experience,' or 'quality or power of projecting one's personality into or mentally identifying oneself with an object of contemplation, and so fully understanding or appreciating it'(OED). • 'emotional response elicited by and congruent with the perceived welfare of someone else' (Batson & Coke 1981, p.169). • Empathetic Concern: state arising from seeing another's distress comprising emotions such as 'compassion, concern, warmth, softheartedness' (Batson & Coke 1981).
Negative mood, state or affect, negative state relief, arousal reduction	Negative mood	• Mood: 'A prevailing but temporary state of mind or feeling; a person's humour, temper, or disposition at a particular time.' (OED, n) • The experience of a negative moods or state, which may not have a specific cause, may not be strong, might be temporary or longstanding, and might not be expressed.
	Temper	• 'Mental balance or composure, esp. under provocation of any kind; moderation in or command over the emotions, esp. anger; calmness, equanimity' (OED, n). • Code includes 'bad, short, ill'.
Over-arousal - effect, excessive empathetic arousal	Over-arousal - effect	• Empathic arousal which is 'so intense as to direct the observer's attention to him- or herself rather than to the victim, with a resulting decrease in the likelihood of an altruistic response' (Hoffman, 1981, p133) • Includes excessive empathetic arousal.
Personal arousal or personal distress (driven by egoistic emotions such as shock, alarm, disgust, shame and fear)	Personal arousal or distress	• Personal distress: state arising from seeing another's distress made up of emotions such as shock, alarm, disgust, shame, fear. (Batson and Coke 1981) • Empathic distress: Observing someone in distress will instigate an empathic distress response. (Hoffman 1981) • Empathetic (or personal) distress 'refers to a strong aversive and self-oriented response to the suffering of others, accompanied by the desire to withdraw from a situation in order to protect oneself from excessive negative feelings' (Singer & Klimecki, 2014, p1). • Likely to driven by egoistic emotions such as shock, alarm, disgust, shame and fear
	Uneasy (ill at ease)	• Emotion or feeling, context or state. • 'Characterized by absence of ease or comfort; suggesting or manifesting want of ease in body or mind' (OED, n). • This code includes 'ill at ease'.

12.9 Appendix 8a: User Distress Narratives

User Pain, Suffering and Distress Narratives	
ELEMENTS	**NARRATIVE SAMPLES**
User Condition	'the patient became extremely concerned that he was going to have a heart attack.' (Patient, Independent Inquiry Report, Volume 2, p.219)
User Condition	'….she was extremely fearful of the diagnosis of cancer; particularly given she had lost her mother to cancer some years earlier.' (Relative, Independent Inquiry, Summary of Oral Evidence, Week 1)
User Condition	'After suffering a seizure the patient was admitted….. She was scared and confused.' (Patient, Independent Inquiry Report, Volume 2, p.40)
User Condition	'The patient was confused and frightened.' (Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.88)
User Condition	'The patient was terrified.' (Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.45)
Deficient Treatment	'the patient's wife was concerned that he was not treated for the cancer and by the time he was discharged he had developed diarrhoea.' (Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.138)
Deficient Treatment	'[REMOVED] waited for three hours before pain relief or assistance were given. This was traumatic and stressful for the patient and her family.' (Patient, Independent Inquiry Report, Volume 2, p.346.)
Deficient Treatment	**'**I had to keep asking for his syringe-drivers to be refilled when they emptied. It just didn't seem to be a priority. On two occasions, I waited for over an hour for a reply to the call-button and eventually I just had to go and find a nurse and insist that they left the patient they were with to come and help... He was crying by that time and in great distress due to the pain he was experiencing.' (Relative, Independent Inquiry Report, Volume 1, p.394)
Deficient Treatment	'On the day she expected to have the scan, [REMOVED] was reassured that she would be sent for the scan, before she was eventually told that the staff had gone home. This was extremely worrying and distressing.' (Relative, Independent Inquiry, Summary of Oral Evidence, Week 2)
Deficient Treatment	'My daughter was so shocked at his appearance that she said something like "What the hell are they doing to you?" and had to leave the room in tears.' (Relative, Public Inquiry, Anonymised Relative 12 Witness Statement, par21, p7.)
Deficient Treatment	'I noticed that the urine container under the bed was full and needed emptying. When I looked closer I discovered that there was also a dirty nightie under the bed, which had obviously been either concealed or forgotten. I found [REMOVED] sitting in her own urine more than once. The bed was wet through. Whenever I asked nurses to come and change [REMOVED], I was upset.' (Relative, Public Inquiry Report, Volume 3, par25.22, p.1604)
Deficient Treatment	'When in the isolation ward, on one occasion, [REMOVED] could not access the call button and was left without help all night. He was very distressed by this experience.' (Patient, Independent Inquiry, Summary of Oral Evidence 3)
Deficient Treatment	'I was bubbling with anxiety about what would happen to older people at the hospital.' (Patient, Public Inquiry, Anonymised Patient 02 Witness Statement, par6, p.6.)

Deficient Treatment	'..she was appalled to observe another patient being told her water had been removed to stop requests for toileting.' (Patient, Independent Inquiry Report, Volume 2, p.244)
Deficient Treatment	'[REMOVED] and her son were also distressed by an elderly patient in a neighbouring bed who was in some difficulty.' (Relative, Independent Inquiry Report, Volume 2, p.291)
Deficient Treatment	'…. it was worse, I thought, for the old lady next to me, who couldn't get out of bed, and she was on a commode at least 15 minutes ringing and ringing, and it went on and on, and she was a very ill lady.' (Patient, Public Inquiry Report, Volume 3, par23.11, p.1501)
Indignities	'She was ignored for long periods by nurses. There was no respect for the patient's dignity.' (Relative, Independent Inquiry Report, Volume 2, p.26)
Indignities	'He felt demeaned. He lost a lot of his dignity, his pride. There was so much taken away from him that – it was just unbelievable to see a man that was so full of life brought down to the – to the state that he was in, that he was frightened to say anything or to be able to stand up to people.' (Relative, Public Inquiry Report, Volume 3, par23.10, p.1501)
Indignities	'my wife's niece came over to stay with us…..she was absolutely shocked at the way a consultant would speak to a patient in the ward, would speak quite loudly so everybody could hear….. didn't pull the curtains round or speak in low tones.' (Relative, Independent Inquiry Report, Volume 1, par211, p.111)
Indignities	'Everyone could have seen her. That is why I was so distressed because my Mum would have been horrified if she would have known that people were walking past and could see her. The door was just left open all the time.' (Relative, Independent Inquiry Report Volume 1, par21, p.55.)
Indignities	'People could be calling for a bedpan or help to get to the toilet: yes, I will be back in a minute. Off they go and they weren't back in a minute. They had no intention of doing it, until people were just left to do it where they were. There was no dignity. There was no care. It was just totally dreadful.' (Relative, Independent Inquiry Report, Volume 1, par206, p.109)
Indignities	'The same thing had happened to the gentleman in the opposite bed. The result was that he couldn't get to the toilet in time so he was in a wet bed. That is distressing enough anyway, let alone for a 77 year old that do [sic] not walk. The loss of dignity that he experienced was just awful; it was really embarrassing for him.' (Relative, Public Inquiry, Anonymised Relative 20 Witness Statement, p.12)
Indignities	'there was a lovely old man in the bed opposite. He obviously had some type of dementia, but he was very gentle and kind, i witnessed him having to wet himself. He was all dressed up in a suit ready to go home. He begged and pleaded for the nurse to bring him the toilet bottle, but she said "You'll have to wait, I'm dealing with so and so's patient". It would only have taken her a moment. The cleaner heard him and she came, but it was too late. There wasn't a curtain round him or anything. It was heartbreaking. There was no dignity. I will never forget it.' (Relative, Public Inquiry, Anonymised Relative 11 Witness statement, par11, P.4)
Indignities	' this guy had got a hospital gown on, and I will never forget him, a tall elderly man. He was covered all the way down in faeces, he was showing all of his genitals,…..I was thoroughly disgusted. I thought a dog at a vet's would not be left like that, and this guy, he has probably fought in two World Wars, has been left.' (Relative, Independent Inquiry Report, par207, p.110)

12.10 Appendix 8b: Agent Distress Narratives

Agent Pain, Suffering and Distress Narratives	
	NARRATIVE SAMPLES
Own Situation	'I put on three stone in weight as I was upset, worried, stressed and I was increasingly suffering asthmatic attacks due to stress.' (Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par67, p.18.)
Own Situation	'I use [sic] to get palpitations when going onto the ward to undertake a ward round, as I felt exposed and vulnerable and was very uncomfortable at being forced to cut corners.' (Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par43, p.10)
Own Situation	'This left me feeling very exposed and vulnerable.' (Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par27, p.9)
Own Situation	'I had become so dispirited.' (Doctor, Public Inquiry, Witness Statement Anonymised Employee 18, par19, p.6)
Colleagues' Situation	'My colleagues were much more stretched and were in a terrible position. I knew how bad it was.' (Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par39, p.11)
Colleagues' Situation	'There was continual discontent from the junior doctors.' (Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par37, p.10)
Colleagues' Situation	'a number of nurses were under a lot of stress, as a result of the wards being heavily understaffed.' (Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par48, p.13)
Colleagues' Situation	'Consultants lost heart.' (Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par3, p.2)
Colleagues' Situation	'Consultants weren't happy and said so but were ground down.' (Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par3, p.2) .'
Colleagues' Situation	'I heard girls in their late 20s crying that they couldn't stand being moved again from ward to ward.' (Doctor, Public Inquiry, Witness Statement Anonymised Employee 18 Witness Statement, par37, p.10)
Colleagues' Situation	'It was clear to me that she had not really wanted the job. I felt quite sorry for her.' (Senior Executive, Public Inquiry, Anonymised Employee 02 Witness Statement, par66)
Colleagues' Situation	'I think she had a very difficult time.' (Senior Executive, Public Inquiry, Anonymised Employee 02 Witness Statement, par73)
Insecurities	'The proposal left people fearing for their jobs.' (Manager, Public Inquiry, Anonymised Employee 11 Witness Statement, par31, p.9)
Insecurities	'people were concerned about how it would affect them personally.' (Manager, Public Inquiry, Anonymised Employee 09 Witness Statement, par52, p.17.)
Insecurities	'I had friends who were nurses who were also very concerned that the reductions would impact on how they performed their jobs.' (Manager, Public Inquiry, Anonymised Employee 11 Witness Statement , par31, p.9)
Insecurities	'A "fear factor" mind set was created when the workforce reductions came in, as people's jobs were not safe and everybody became wary.' (Manager, Public Inquiry, Anonymised Employee 11 Witness Statement, par32, p.9)
Insecurities	'we were hearing about redundancies within the NHS on a daily basis.' (Senior Executive, Public Inquiry, Anonymised Employee 07 Witness Statement, par37, p.9)

12.11 Appendix 9: Buzzer Routine

Buzzer Routine Narratives	
ELEMENTS	**NARRATIVE SAMPLES**
Buzzers unanswered	'On two occasions, I waited for over an hour for a reply to the call-button.' (Relative, Independent Inquiry Report, Volume 1, p.394)
Buzzers unanswered	'On a number of occasions, [REMOVED] rang the buzzer for lengthy periods in order to get assistance to go [sic] the toilet.' (Relative, Independent Inquiry, Summary of Oral Evidence, Week 2)
Buzzers unanswered	'When [REMOVED] visited her mother, other patients would say that her buzzer had been ringing for a considerable amount of time.' (Relative, Independent Inquiry, Summary of Oral Evidence, Week 2)
Buzzers unanswered	'There was a time when I was suffering from vomiting, I had been pressing the buzzer for a long time but nobody came and I was left to vomit on my bedclothes.' (Patient, Public Inquiry, Anonymised Patient 01 Witness Statement, par12, p.4)
Buzzers unanswered	'[REMOVED] told the Inquiry that on one occasion, several patients in his bay buzzed for nursing staff but no one came. Instead the patients had to shout to attract the attention of the nurses.' (Patient, Independent Inquiry, Summary of Oral Evidence, Week 2)
Buzzers unanswered	'After about 20 minutes you could hear the men shouting for the nurse, "Nurse, nurse", and it just went on and on. And then very often it would be two people calling at the same time and then you would hear them crying, like shouting "Nurse" louder, and then you would hear them just crying, just sobbing, they would just sob and you just presumed that they had had to wet the bed. And then after they would sob, they seemed to then shout again for the nurse and then it would go quiet …' (Relative, Public Inquiry Report, Volume 3, par23.8, p.1500)
Buzzers unanswered	'In Mum's bay the woman in the next bed, she would sound the buzzer and it would just go off and off and off and then the same – it was the same thing, she would just call out for the nurse.' (Relative, Independent Inquiry Report, Volume 1, par26, p.57)
Buzzers unanswered	'an old man on ward 11 pressed a buzzer over and over again as he wanted to urinate. He was a frail chap with poor mobility, and as the buzzer was not answered, he eventually went to the loo in the early hours of the morning and broke a hip. He went in for surgery and died the next day. I recall attending the inquest, the outcome of which was that the non availability of nurses was partly at fault.' (Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par83, p.19)
Buzzers unanswered	'Nurses were so busy that ringing the bell was a pointless exercise.' (Patient, Independent Inquiry Report, Volume 2, p.128)
Buzzers unanswered	'The effect was that the [REMOVED] contained significant numbers of patients in distress and, as a department, we were immune to the sound of pain.' (Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement One, par13, p.4)
User Prevention (Deterrence)	'The emergency button was often left out of reach.' (Relative, Independent Inquiry Report, Volume 2, p.23)

User Prevention (Deterrence)	'The patient's buzzer was left on the wall out of his reach.' (Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.43)
User Prevention (Deterrence)	'..call bells were rarely answered and in any case were frequently placed out of the reach of patients.' (Relative, Independent Inquiry Report, Volume 1, p.392)
User Prevention (Deterrence)	'When in the isolation ward, on one occasion, [REMOVED] could not access the call button and was left without help all night.' (Relative, Independent Inquiry, Summary of Oral Evidence, Week 3)
User Prevention (Deterrence)	'The nurses told her to ring the buzzer, but because of her paralysis she could not use the buzzer.' (Relative, Public Inquiry Report, Volume 3, par23.6, p.1499)
User Prevention (Deterrence)	'…he rang the buzzer but no one came. He later discovered the buzzer did not work.' (Patient, Independent Inquiry Report, Volume 2, p.26)
User Prevention (Deterrence)	'When she pressed her buzzer to get assistance for an older patient a nurse informed her "they had purposely not given this old lady a buzzer, she was a nuisance".' (Patient, Independent Inquiry Report, Volume 2, p.127).
Consequences	'[REMOVED] recalls that her husband was infrequently washed and given clean clothes, despite frequently soiling himself. She recalls that her husband had sores on his bottom and on his heels. She states that her husband rang the bell for toileting assistance but by the time the nurses arrived it was too late. She reports that she used to ring the bell for 20 minutes before it was responded to.' (Relative, Independent Inquiry Report, Volume 2, p.333)
Consequences	'He would also come in and find me lying in my own vomit, urine, and on one occasion, I was suffering from severe violent diarrhoea. I had been buzzing for some time as my Stoma bag had burst. I was embarrassed and ashamed when my mum walked in to see me in that state.' (Patient, Public Inquiry, Anonymised Patient 01 Witness Statement, par15, p.5)
Consequences	'In Mum's bay the woman in the next bed, she would sound the buzzer and it would just go off and off and off and then the same – it was the same thing, she would just call out for the nurse. When the nurse did come, she would be put on to the commode and it was obviously too late. The nurse would put her back into the bed, you could hear her – she would wait on the commode for half an hour and very often she would just try to make it herself and just go smack on to the floor.' (Relative, Independent Inquiry Report, Volume 1, par14, p.53)
Consequences	**'**I had to keep asking for his syringe-drivers to be refilled when they emptied. It just didn't seem to be a priority. On two occasions, I waited for over an hour for a reply to the call-button and eventually I just had to go and find a nurse and insist that they left the patient they were with to come and help... He was crying by that time and in great distress due to the pain he was experiencing.' (Relative, Independent Inquiry Report, Volume 1, p.394)
Consequences	'…. it was worse, I thought, for the old lady next to me, who couldn't get out of bed, and she was on a commode at least 15 minutes ringing and ringing, and it went on and on, and she was a very ill lady.' (Patient, Public Inquiry Report, Volume 3, par23.11, p.1501)

12.12 Appendix 10: Member Friction

Friction between Organisational Agents and Users	
ELEMENTS	**NARRATIVE SAMPLES**
Unfriendly or unwelcoming	'They just totally ignored me. There was no niceties. There was no: good morning, Mrs [...], how are you? When they did anything for [my husband], it was never: Mr […], I am going to do so and so; or Mr [...]; or whatever. They just treated him as if he wasn't there.' (Relative, Independent Inquiry Report, Volume 1, par310, p.137)
Unfriendly or unwelcoming	'The staff were so unapproachable there. It was just the looks they gave when we came back in.' (Relative, Public Inquiry, Anonymised Relative 01 Witness Statement, par40, p.12)
Unfriendly or unwelcoming	'it was the eye roll, the tutting from the nurses that I remember, it was not what they said, it was the way they used to say it. It was the attitude and the looks and I can still remember that'. (Relative, Public Inquiry, Anonymised Relative 01 Witness Statement, par25, p.8)
Unfriendly or unwelcoming	'I recall hundreds of instances of raised eyebrows or the flick of the head from the Hospital staff.' (Relative, Public Inquiry, Anonymised Relative 01 Witness Statement, par36, p.11)
Unfriendly or unwelcoming	'the nurses never spoke. They didn't know how to behave socially, I don't think. They spoke to one another though, having said that. They would carry on conversations over your head but they would never once acknowledge you. You were an absolute pain because – I used to get there at about 9.15, 9.30 every morning, and I always asked permission to go on to [the ward] – is it convenient for me to go on to the ward to stay with [my husband]? I sat, held his hand and wiped his face and his hands and washed his mouth. Just there to comfort him and do whatever I could. But they didn't hide the fact that they didn't like me being there.' (Relative, Independent Inquiry Report, Volume 1, par206, p.110)
Unfriendly or unwelcoming	'One day I demanded to see a Doctor and had a conversation with a [REMOVED] (I think that was his name). Mum said to him "I'm dying" and he said "I assure you [REMOVED] you're not" at which point I said "when are you going to call her [REMOVED]?".' (Relative, Public Inquiry, Anonymised Relative 07 Witness Statement, par13, p.3)
Unfriendly or unwelcoming	'The nurses made her feel like she was a burden.' (Patient, Independent Inquiry Report, Volume 2, p.113)
Unfriendly or unwelcoming	'I think the initial comment of the nurse which said: we don't like you visiting during mealtimes.' (Relative, Independent Inquiry Report, Volume 1, par128, p.88)
Unfriendly or unwelcoming	'we were a nuisance. They didn't really want us there. The whole attitude was "Don't bother us, we're busy. Don't ask anything, we haven't got the answers". It was looks and shrugs of the shoulders and things like this if you made a query, you know, as to my mum's health or was anything happening or – you know any query at all.' (Relative, Public Inquiry Report, Volume 3, par25.30, p.1606)
Unfriendly or unwelcoming	'there were a couple that were very nice, very, very helpful, but the majority, no. It was a lot of the looks and the shrugs and "Yes, we'll do it", you know "when I've got the time", and, you know, you're a pain.' (Relative, Public Inquiry Report, Volume 3, par25.30, p.1606)

Incivilities (rudeness)	'She observed patients being antagonised by the nurses who were rude and dismissive.' (Patient, Public Inquiry Report, Volume 2, p.22)
Incivilities (rudeness)	'This nurse practitioner told me to "shut up".' (Relative, Public Inquiry, Anonymised Relative 07 Witness Statement, par23,p.6)
Incivilities (rudeness)	'..she said to my Mum:… what medication have you had today? Is Mum supposed to remember that?... and my Mum had said: sorry, what did you say? And she snapped: I said, what medication did you have? I said: excuse me, I didn't understand what you said, you'd mumbled it.' (Relative, Independent Inquiry report, Volume 1, par295, p.134)
Incivilities (rudeness)	'She would often soil herself, and some of the nurses and the auxiliary staff were actually, whilst I was there, were quite, I would say stroppy, almost.' (Relative, Independent Inquiry Report, Volume 1, par39, p.60
Incivilities (rudeness)	'Some of the staff were caring but others had a brusque manner.' (Relative, Independent Inquiry Report, Volume 2, p.188)
Incivilities (rudeness)	'when she attended the [REMOVED], the nurse was abrupt and bad mannered.' (Patient, Independent Inquiry Report, Volume 2, p.270)
Incivilities (rudeness)	'Her daughter found that the staff were very uncommunicative about her mother's condition and extremely abrupt.' (External Organisation, Independent Inquiry Report, Volume 2, p.131)
Incivilities (belittling patronising)	I was admitted to the Hospital and the following morning a very scruffy consultant came and said to me "Now you've had your bed and breakfast, you can go home". I was absolutely stunned by his attitude.' (Patient, Public Inquiry, Anonymised Patient 03 Witness Statement, par42, p.12)
Incivilities (belittling patronising)	'I found the nurses' approach very patronising…They were very flippant and were clearly just paying lip service to the issues. They were extremely patronising and asked me if, once I had got over my grief, I would be prepared to provide training to their nursing staff. I was outraged by this.' (Relative, Public Inquiry, Anonymised Relative 07 Witness Statement, par42, p.10)
Incivilities (belittling patronising)	'I recall that when [REMOVED] was on the stroke ward, the nurses were horrible at the time. They were laughing at patients who weren't able to do anything for themselves. There was no care at all.' (Relative, Public Inquiry, Anonymised Relative 12 Witness Statement, par28,p.9)
Incivilities (belittling patronising)	'She was admitted to [REMOVED] at Stafford Hospital where her husband was very upset to hear a male nurse joking about her predicament. He spoke to the other nurses and found that his behaviour was fairly typical.' (Relative, Independent Inquiry Report, Volume 2, p.259)
Incivilities (belittling patronising)	'her husband informed her of an incident whereby two nurses were talking and laughing about the patients, she reports that her husband actually confronted the nurses about their lack of respect for the patients on this occasion.' (Relative, Public Inquiry, Summary of Oral Evidence, Week 3)
Incivilities (belittling patronising)	'I went to see one of the nurses to explain that I thought it was something more serious and the nurse said to me "if you don't think it is a panic attack, you find out what it is" and gave me a medical book to look through.' (Relative, Public inquiry, Anonymised Relative 19 Witness Statement One, par36, p.14)
Hostilities	'And she huffed and she puffed and she banged the door and she left…. She just walked off.' (Relative, Independent Inquiry report, Volume 1, par295, p.134)

Hostilities	'… he said: I need to go to the toilet. … he said she seemed quite angry that he wanted to go to the toilet. So she flounced out.' (Relative, Independent Inquiry Report, Volume 1, par15, p.154)
Hostilities	'[REMOVED] told his wife that he had asked a nurse for help to go [sic] the toilet but the nurse had got angry before leaving to find a bottle. [REMOVED] was not able to wait and he told his wife that the nurse had 'exploded' and threw either the urinal or the food tray onto the bed and left.' (Patient, Independent Inquiry, Summary of Oral Evidence, Week 1)
Hostilities	'a nurse came in and literally threw documents at her that she said she would need for the funeral.' (Patient, Independent Inquiry, Summary of Oral Evidence, Week 3)
Hostilities	'My father was lambasted by one of the senior nurses for the suicide attempt because she said it was a selfish act.' (Relative, Independent Inquiry Report, Volume 1, par19, p.155)
Hostilities	'a very, very stroppy sister threatened to have me thrown off the ward altogether because I was being very emphatic in wanting to see somebody who had information as to what was the matter..' (Relative, Independent Inquiry Report, Volume 1, par281, p.130)
Hostilities	'…she was due to go on a break, and he said to her: I'm really sorry but I have done it, and with that she exploded. She threw the urinal down on to the bed and she pushed his trolley up against where he was with his dinner and she went out and she never came back.' (Relative, Independent Inquiry Report, Volume 1, par15, p.154)
Hostilities	'at one point they had a basket at the end of the bed that they would put sheets into, and we would go in and they were covered in urine, and they were covered in faeces and the smell. And we would constantly drag this out and put it outside of the room and said: please, would you not leave this in my Mum's room because all of the germs are airborne and they are – as soon as we had gone, it would be put straight back in again.' (Relative, Independent Inquiry Report, Volume 1, par39, p.61)
Hostilities	'I do not believe that the staff were happy about the fact that I had raised a complaint, because they did strange things like take the visiting chair away when my daughter went to sit with him, and consequently she had to sleep on the floor when she visited.' (Relative, Public Inquiry, Anonymised Relative 10 Witness Statement, par17.1, p.4/5)
Hostilities	'Despite family complaints, the nurses left the door to the room open and chairs from her room were frequently borrowed.' (Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.104)
Hostilities	'I continued to stay with mum at all times but the nights were dreadful. The first three or four nights there wasn't even a chair for us to sit in. Whenever we did find one, we would go to the toilet and come back and find it gone. The nurses made it perfectly clear that they didn't want us there. They had no interest in making us comfortable and in fact made it very clear they didn't want us there at all.' (Relative, Public inquiry, Anonymised Relative 19 Witness Statement One, par25, p.10)
Hostilities	'I was standing outside my father's room, she came out to get something and on her way back in she said to me: if you don't disturb us, we won't disturb you. I said: pardon? She said: I didn't mean it like that. I thought to myself: you flipping well did, you would not have said it otherwise. Which upset me.' (Relative, Independent Inquiry Report Vol 1, par143, p.92)

12.13 Appendix 11: Diminishment Narratives

Friction: User Diminishment Narratives	
ELEMENTS	**EXAMPLES**
Reduced Humanity or Personhood	'The attitude of staff could be variable, some demonstrating a commendable recognition of the humanity of those they engaged with while others did not.' (Inquiry Chairman, Independent Inquiry Report, Volume 1, par205, p.109)
Reduced Humanity or Personhood	'She hated being called [REMOVED] and, although we asked on numerous occasions that she was called [REMOVED], everyone kept calling her [REMOVED]. This upset me, as Mum had limited hearing and sight. If you call someone by a name that they are not known as, they are not going to respond.' (Relative, Public Inquiry, Anonymised Relative 07 Witness Statement, par5, p.2)
Reduced Humanity or Personhood	'The nurses never offered me any conversation; they never even addressed me as a person. They never spoke to [REMOVED] either. They never mentioned his name, and they certainly never mentioned mine.' (Relative, Public Inquiry, Anonymised Relative 11 Witness Statement, par7, p.3)
Reduced Humanity or Personhood	'…their mother was not treated as an individual. It was their perception that none of the patients they observed were treated as though they were an individual person.' (Relative, Independent Inquiry, Summary of Oral Evidence, Week 3)
Reduced Humanity or Personhood	'I think my experience with the nursing staff, they don't actually – it isn't care at all, it is – you are a number.' (Role, Independent Inquiry Report, Volume 1, par23, p.156)
Reduced Humanity or Personhood	'When they did anything for [my father], it was never: […], I am going to do so and so; or Mr […]; or whatever. They just treated him as if he wasn't there. As if he was just – well, as I said, a log of wood or something like that.' (Relative, Independent Inquiry Report, Volume 1, par27, p.157)
Reduced Humanity or Personhood	'We didn't see anyone treated as an individual. We were a commodity to be shifted through the system as quickly as possible. That is the feeling you got, observing 24/7.' (Relative, Independent Inquiry Report, Volume 1, par294, p.133)
Reduced Humanity or Personhood	'Nursing staff continually called her by her Christian name, completely disregarding her frequent requests to be referred to by her full name. This made her angry.' (Patient, Independent Inquiry report, Volume 1, p.293)
Denigrating, Demeaning or Dehumanising.	'The patient was told that he was a 'dirty old man' and that he should 'not expect his sheets to be changed each time.' (Independent case notes review, Independent Inquiry Report, Volume 2, p.126)
Denigrating, Demeaning or Dehumanising.	'There were two nurses that were actually talking about the patients, and they were laughing about them, and my husband did actually turn round to them and say: excuse me, I might have had a stroke but I do know what is going on… They had just come out of the ward and were laughing and saying about the smell in there, and they were talking in general, thinking that because he had had a stroke, he wasn't able to understand that they were actually taking the mickey out of the patients.' (Patient, independent Inquiry Report, Volume 1, par28, p.257)

Denigrating, Demeaning or Dehumanising.	'Staff also made derogatory comments about her partner: "Young enough to be your son".' (Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.270)
Denigrating, Demeaning or Dehumanising.	'She was ignored for long periods by nurses. There was no respect for the patient's dignity.' (Relative, Independent Inquiry Report, Volume 2, p.26)
Denigrating, Demeaning or Dehumanising.	'He felt demeaned. He lost a lot of his dignity, his pride. There was so much taken away from him that – it was just unbelievable to see a man that was so full of life brought down to the – to the state that he was in, that he was frightened to say anything or to be able to stand up to people.' (Relative, Public Inquiry Report, Volume 3, par23.10, p.1501)
Denigrating, Demeaning or Dehumanising.	'….the doctor has told you that there is nothing wrong with you and that you are simply used to being in charge — now you are not in charge and that is your problem.' (Relative, Public Inquiry, Anonymised Relative 19 Witness Statement One, par17, p.7)
Blaming or Scapegoating	'She informed the hospital that she had consumed some alcohol, whereupon her daughter believes the doctor's attitude changed and "she was not treated with the same care". The patient was then discharged and told it was "nothing acute".' (Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.71)
Blaming or Scapegoating	'Her husband was unhappy with the consultant's attitude, primarily as he seemed to be convinced that his wife was suffering from alcohol-induced pancreatic disease. Her family constantly emphasised that she only consumed alcohol occasionally and never to excess, and indeed had drunk very little since her first pregnancy in 1978. The family believe that the consultant's assumption and refusal to listen to the family clouded his judgement.' (Relative, Independent Inquiry Report, Volume 1, p.148)
Blaming or Scapegoating	'many patients suffered from acute confusional states……some medical staff did not understand this diagnosis and its importance and in some instances treated it as 'bad behaviour' rather than as a valid medical condition.' (Inquiry Chairman, Independent Inquiry Report, Volume 1, par21, p.401)
Blaming or Scapegoating	'I said why – you have rushed the blood through, I said to the sister, and she said – she said – no, she said, what has happened is I have had to come in and give the blood and don't moan, she said, because I have had no break today.' (Relative, Independent Inquiry Report, Volume 1, par6, p.153
Blaming or Scapegoating	'Following her husband's death his wife was spoken to by a nurse in the pub who said "her husband was disgusting to get so fat, he needed every porter in the hospital to move him".' (External Organisation, Independent Inquiry Report, Volume 2, p.106)
Blaming or Scapegoating	'The same nurse who was previously reprimanded for her unacceptable behaviour came back into my room. She said "you've made me ill! I have been off sick with stress because you reported me!". I find this totally unacceptable and a demonstration of the fact that some of the nurses simply do not care about patients' feelings.' (Patient, Public Inquiry, Anonymised Patient 01 Witness Statement, par11, p.4)

12.14 Appendix 12: High-Strain Narrative

HIGH STRAIN NARRATIVES
EXAMPLES
'We were all working crazy hours, perhaps 70 to 80 hours per week and we were on call on top of this. Working at this pace created its own problems. One Consultant went on long-term sick leave and we had a problem with illness.' (Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par67, p.21)
'…. Nurses in particular felt that there was pressure to care for patients in a given timeframe.' (Doctor, Public Inquiry, Anonymised Employee 21 Witness Statement, par66, p.15)
'On one occasion she was shocked to see the same doctor on duty for over 24 hours.' (Patient, Independent Inquiry Report, Volume 2, p274)
'People were busy running around, doing three things at once and not taking breaks, or lunch.' (Manager, Public Inquiry, Anonymised Employee 09 Witness Statement, par5, p.2)
'I waited for four and half hours while one extremely harassed doctor raced around like a headless chicken.' (Patient, Public Inquiry, Anonymised Patient 02 Witness Statement par3, p.2)
'They didn't really have time. There were not enough around.' (Patient, Public Inquiry, Patient A Witness Statement, p.101)
'People, and certainly nurses, were under more and more pressure and they did not have the amount of time they thought they should have to offer their patients.' (External Individual, Public Inquiry, Anonymised External 96 (GP) Witness Statement, par10, p.3)
'The porter told me that he was struggling to find an oxygen cylinder that actually contained some oxygen as they were all empty. The porter was quite anxious and he told me that he had a 15 minute slot in which to move mum or he would be in trouble.' (Relative, Public Inquiry, Anonymised Relative 19 Witness Statement One, par18, p.8)
''There were not enough hours in the day.' (Senior Executive, Public Inquiry, Anonymised Employee 06 Witness Statement, par43, p.12)
'Nurses were often forced to work very long hours and take administrative work home as there wasn't time to complete this when in the hospital.' (Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par72, p.20)
'When [REMOVED] first arrived she was met with a huge workload,' (Other Employee, Public Inquiry, Anonymised Employee 05 Witness Statement Number, par, p.11)
'I was up until 1.00am typing my report, even though I was due back on shift at 7.00am.' (Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par19, p.6)
'….the nurses there weren't unkind to him, but they were overworked.' (Relative, Independent Inquiry report, Volume 1, par20, p.55)
'…the patient's wife was concerned that there was a lack of staff to provide adequate care and found that nurses often worked double shifts.' (Relative, Independent Inquiry Report, Volume 2, p.236)
'There were also very few nursing staff on the ward and they came across as 'overworked, ill-informed and careless'.' (Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.119
'We worked this hard because we believed strongly in improving the Department. The difficulty is that if you work a team that hard for so long you begin to break people. We broke one Consultant and therefore ended up with three, making our work even harder.' (Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par88, p.26).
'I was working under pressures that would have broken most people' (Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par14, p.4)

‘We [sic] all exhausted, mentally and physically. We are fed up with tackling unmanageable workloads, going without breaks, not getting off on time, doing extras with no respite. The environment is neither safe for patients or staff.’ (Anonymous Letter, Independent Inquiry Report Volume 1, par78, p.205)
‘On the ward there were not enough staff and the nurses were clearly exhausted.’ (Patient, Independent Inquiry Report, Volume 2, p.70)
‘The nurses were overwhelmed with the number of patients, one crying with exhaustion and frustration.’ (Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.45)
‘Whilst on the ward her son was concerned by the lack of staff. He found one nurse crying as she had worked for 12 hours without a break and at the weekend.’ (External Organisation, Independent Inquiry Report, Volume 2, p.135)
‘I saw lots of examples of simply not enough nursing care.’ (Doctor, Public inquiry, Anonymised Employee 18 Witness statement, par35, p.100)
‘…there were simply not enough people to provide basic care. In the circumstances, the nurses had to make choices about how to spend their time.’ (Senior Executive, Public Inquiry, Anonymised Employee 02 Witness Statement, par78)
‘Clinical Leads were still doing their full time clinical jobs and simply did not have the necessary time needed to devote themselves to effective management.’ (Doctor, Public Inquiry, Anonymised Employee 14 Witness Statement, par9, p.4)
‘The vast majority of nurses wanted to spend more time with the patients, and their families and carers, but due to the pressure of work and the impact of the low staffing levels, they were not able to do this and were not able to communicate as much as they would have wanted to.’ (Doctor, Public Inquiry, Anonymised Employee 21 Witness Statement, par34, p.9)
‘There were too few doctors and nurses, alongside poor training and supervision, and junior doctors were put under pressure to make decisions quickly without advice and support from more senior doctors.’ (Healthcare Commission Report, 2009, p.7)
‘.. there was certainly great and increasing disquiet regarding the pressure of work on nurses following staffing cuts at the Hospital….It was clear that there was increasing disquiet in the Hospital regarding inadequate levels of staffing.’ (External Individual, Public Inquiry, Anonymised External 96 (Witness Statement, par10, p.3)
‘In my view [REMOVED] had his hands tied. He had to balance the books; he had to get FT status and he had to sort the problems out at the Trust notwithstanding that money had been taken out.’ (Doctor, Public Inquiry, Anonymised Employee 19 Witness Statement, par15, p.5)
‘…it had been made crystal clear to me by the SHA that come what may, the hospital had to break even by the end of the financial year.’ (Senior Executive, Public Inquiry, Anonymised Employee 06 Witness Statement, par53, p.15)
‘I believe this requirement to cut the budget would have come right from the top.’ (Doctor, Public Inquiry, Anonymised Employee 19 Witness Statement, par14, p.5)
‘I was required to achieve financial balance within the one year. This was reiterated at the monthly meetings where target sheets were handed round so that all could see how each hospital was progressing.’ (Senior Executive, Public Inquiry, Anonymised Employee 06 Witness Statement, par147, p.48)

12.15 Appendix 13: Low Support Narrative

Low Support Narratives	
ELEMENTS	**NARRATIVE SAMPLES**
Resourcing	'On the ward there were not enough staff and the nurses were clearly exhausted.' (Patient, Independent Inquiry Report, Volume 2, p.70)
Resourcing	'The Department by this stage was hideously under-resourced.' (Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par47, p.14)
Resourcing	'I remember a conversation with one of the senior nurses who told me that she was on her own and had 50 meals to serve.' (Relative, Public Inquiry Report, Volume 2, par25.17, p.1601)
Resourcing	'…an understaffed and under resourced department, was "horrendous".' (Manager, Public Inquiry Report, Volume 1 , par2.341, p.277)
Resourcing	'This situation put the consultants in an unacceptable, invidious, and extremely frustrating position. They were denied the basic tools they need to do their job properly.' (Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par40, p.10)
Agent Friction	'It was also clear to me that there were certain factions within the management team.' (Senior Executive, Public Inquiry, Anonymised Employee 06 Witness Statement, p.15)
Agent Friction	'..interpersonal relationships between the consultant surgeons were generally poor.' (Doctor, Public Inquiry, Anonymised Employee 22, Witness Statement, par84, p.24)
Agent Friction	'My view was that the [REMOVED] contained strong personalities, who were quite assertive individuals. If the [REMOVED] did not agree on a topic, they would make this quite clear and the meetings could become quite unpleasant.' (Doctor, Public Inquiry, Anonymised Employee 22, Witness Statement, par84, p.24)
Agent Friction	'There were clear clashes of ethos, ego, and basic philosophy.' (Doctor, Public inquiry, Anonymised Employee 15, Witness Statement, par6, p.2)
Agent Friction	'…instead of being at the top table presenting the plans, he was sitting right at the back and haranguing the top table.' (Doctor, Public inquiry, Anonymised Employee 15, Witness Statement, par29, p.9)
Agent Friction	'There seemed to be an endemic atmosphere of aggression in meetings with the [REMOVED]. I think that a lot of the tension focused around money. Whenever we talked about money the conversation became hostile.' (Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par41, p.12)
Agent Friction	'There was some issue regarding the aggressive behaviour of bed management and trainees often felt intimidated.' (External Organisation, Public Inquiry Report, Volume 2, par18.173, p.1243)
Disregarding (not listening)	'A few of my senior clinical colleagues were represented on the Trust Board, but I do not think they had a significant voice.' (Doctor, Public Inquiry, Anonymised Employee 21 Witness Statement, par62, p.14)
Disregarding (not listening)	'…the medical staff felt that they didn't have a voice. I think they felt they were not listened to so therefore there was no point speaking up.' (Senior Executive, Public Inquiry, Anonymised Employee 02 Witness Statement, p.67)
Disregarding	'… these consultants were helpful to our cause in raising poor staffing levels as a concern but it was clear that the senior management were not listening.'

(not listening)	(Senior Executive, Public Inquiry, Anonymised Employee 13 Witness Statement, par47 p.13)
Disregarding (not listening)	'Many consultants considered that they were not listened to, and that the trust did not welcome constructive criticism or heed concerns that proposals could have a negative effect on the care of patients.' (Healthcare Commission Report, 2009, p.105)
Disregarding (not listening)	'I was upset, and my staff were upset but unfortunately I as their manager was unable to assist them as members of the Executive team were not listening to anything I was saying.' (Senior Executive, Public Inquiry, Anonymised Employee 13 Witness Statement, par67, p.18)
Suppressing	'I noticed that there appeared to be a general lack of engagement between the management and the senior clinicians due to the fact that the clinicians were feeling disenfranchised.' (Doctor, Public Inquiry, Anonymised Employee 17 Witness Statement, par11, p.4)
Suppressing	'The [REMOVED] always took the view that he had to support the Trust Board.' (Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par39, p.11)
Suppressing	'Those Consultants who were involved in management would have nothing to do with the dissent.' (Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par3, p.2)
Suppressing	'I was surprised that the [REMOVED] wasn't more supportive to us but she towed the party line, in that she agreed with the senior Executives….' (Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par46, p.12)
Suppressing	'I felt that the response we received to these concerns was intimidating. I believe I was viewed as being a troublemaker, rather than someone raising genuine concerns.' (Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par95, p.21)
Suppressing	'..you just didn't put your head above the parapet because you would be in trouble if you did.' (Senior Executive, Independent Inquiry Report, Volume 1, par76, p.168)
Suppressing	'I thought that this was a serious issue but found that if I protested I was considered to be awkward. Every day was a battle, and I just wanted to go on the ward rounds and not have arguments.' (Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par78, p.18)
Suppressing	'..if you asked a Ward Sister for example "do you have enough staff?" she would always respond "yes" as the staff do not want to get into trouble.' (Non-Executive, Public Inquiry, Anonymised Non-Executive 06 Witness Statement, par8, p.3)
Suppressing	'The experience of the few nurses at Stafford who sought to stand up for proper standards suggests that doing this can result in discouragement and isolation.' (Inquiry Chairman, Public Inquiry Report, Volume 3, par23.63, p.15.17)
Suppressing	'whenever I actually said something at the meetings the rest of the attendees would carry on as if I had never said anything.' (Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par25, p.7)
Suppressing	'Some time ago I told [REMOVED] and a [REMOVED] that I did not think that the [REMOVED] was staffed to a satisfactory level. I was told that it was and made to feel that I was wrong for having even raised the issue.' (Doctor Independent Inquiry Report, Volume 1, par19, p.215)

Bullying or Intimidating	'There was a culture of bullying and harassment towards staff.' (Doctor, Public Inquiry Report, Volume 1, par1.241, p120)
Bullying or Intimidating	'There was a blame-led culture, the attitude being that problems had to be fixed or nursing jobs would be lost.' (Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par9, p.3)
Bullying or Intimidating	'….when the [REMOVED] was under pressure, this could sometimes create a feeling of blame.' (Doctor, Public Inquiry, Anonymised Employee 22 Witness Statement, par176, p.47)
Bullying or Intimidating	'We feel compromised, bullied and disempowered. The ward no longer belongs to us. And [on] occasion we almost feel derided.' (Anonymous Letter, Independent Inquiry Report Volume 1, par78, p.205) MOVE
Bullying or Intimidating	'She didn't like to be criticised at all. If something was happening that she didn't approve of, didn't like, then your life was made hell. Several of the nursing staff who came to talk to me about their problems they had got with her were saying: I can't do any more because if I do she will just make my life hell.' (Senior Executive, Independent Inquiry Report, Volume 1, par39, p.160)
Bullying or Intimidating	'I really had to fight for this issue, and felt vilified and intimidated for raising it.' (Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par46, p.11)
Bullying or Intimidating	'The former [REMOVED], [REMOVED], was frequently mentioned by witnesses as having a management style which was forceful, and was viewed by some as bullying. [REMOVED] told me: "People were very afraid of the [REMOVED] [REMOVED]".' (Senior Executive, Independent Inquiry Report, Volume 1, par39, p.160)
Bullying or Intimidating	'..their response was extremely aggressive, basically telling me that they were in charge and accusing me, and anyone else who agreed with me, of not being team players.' (Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par13, p.5)
Bullying or Intimidating	'….a lot of other people came forward to complain about the poor practice and bullying culture in [REMOVED]. However, the climate of fear still existed and so many people did so anonymously. … The way that I was treated put many people off raising their heads above the parapet.' (Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par21/22, p.7)
Bullying or Intimidating	'….a band of doctors, who had been bullied by the [REMOVED] into rushing their diagnoses, wrote a joint statement. However, they were later persuaded to retract this when a superior told them that it would not look good on their record.' (Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par21/22, p.7)
Bullying or Intimidating	'[REMOVED] was one of the worst for frightening people, coming down and pressurising people, which is why it led to lying.' (Nurse, Independent Inquiry Report, Volume 1, par58, p.164)
Sanctioning	'I had the impression that the [REMOVED] did not like me objecting to things and that they found me a nuisance.' (Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par15, p.5)
Sanctioning	'Even though I raised concerns revealed by incident reports at JNCC meetings and these issues were raised at surgical directorate meetings, there was a general perception by the Executive team that the nursing staff were moaning.' (Senior Executive, Anonymised Employee 13 Witness Statement, par58, p.16)

Sanctioning	'Unfortunately when nurses raised issues about staffing levels not being safe [REMOVED] put pressure on them to not raise their complaints formally. I am aware that she would advise staff that if they considered staffing levels were unsafe that this was a breach of the NMC Code of Conduct for the nursing profession, and they should be very careful about what they put in a formal complaint as it might lead to them losing their job.' (Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par59, p.16)
Sanctioning	'The culture in the Trust was that staff should be careful about what they say. In particular [REMOVED], the Trust's [REMOVED] at the time, would often say to staff that if they valued their job then they should stop moaning.' Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par72, p.20)
Sanctioning	'My relationship with the [REMOVED], [REMOVED], was not good. She thought I was a troublemaker and had accused me of breaching the provisions of the Code of Conduct by communicating with the press. She in fact summoned me to a disciplinary meeting with her.' (External Individual, Public Inquiry, Anonymised External Individual 14 Witness Statement, par33, p.9)
Sanctioning	'As a result of this, I believe that [REMOVED] did not consider me to be "playing the team game".' Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par70, p.16)
Sanctioning	'If you care about your patients and your work, you had a problem (you were deemed as a problem!).' (Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par41, p.10)
Sanctioning	'I was completely ignored and they carried out inspections without using the sheets prepared. To say that I felt ostracised would be putting it mildly.' (Other Role, Public Inquiry, Anonymised Non-Executive 07 Witness Statement, par40, p.13)
Sanctioning	'One of my colleagues who also complained regularly was suspended after something happened on a ward. He had been fairly vocal in criticising the Hospital and I suspect the real reason behind his suspension was because he was becoming a problem.' (Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par52, p.14)
Sanctioning	'I seem to recall that I had tried to raise this issue but by this stage I was completely ostracised by the Hospital anyway.' (Other Role, Public Inquiry, Anonymised Non-Executive 07 Witness Statement, par68, p.21)
Labelling	'I would always want to know the weight of my patients, or their fluid intake etc, but over time this was not considered part of my job, and I was seen as awkward for asking such questions.' (Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par78, p.18)
Labelling	'I believe I was viewed as being a troublemaker, rather than someone raising genuine concerns.' (Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par95, p.22)
Labelling	'Indeed, it was very clear that I was regarded as a trouble maker.' Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par65, p.15)
Labelling	'The response was always that we had to do what we were told and were "naughty boys" for objecting.' (Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par2, p.4)
Labelling	'The consistent reaction from the PPIF when I verbally raised these concerns was praise for the Hospital and a view that it had done them an excellent service and that "there will always be some people who moan".' (Board

	Member, Public Inquiry, Anonymised Non-Executive 07 Witness Statement, par35, p.12)
Labelling	'I would keep asking questions on the ward round, but no one could answer me. After a period of time I think people began to see me as being awkward and not being a "team player".' (Doctor, Public Inquiry, Anonymised Employee 20 Witness Statement, par41, p.10)

12.16 **Appendix 14a: Cognitive Detachment**

Cognitive Detachment Narratives	
ELEMENTS	**NARRATIVE SAMPLES**
Withdrawn or self-absorbed	'..it was like the lights are on but there was no sign of life.' (Relative, Public Inquiry, Anonymised Relative 11 Witness Statement, par9, p.3)
Withdrawn or self-absorbed	'I had the sense that he was just going through the motions.' (Relative, Public Inquiry, Anonymised Relative 17 Witness Statement, par22, p.5)
Withdrawn or self-absorbed	'I know I am nobody and it doesn't matter, but, surely, courtesy… nobody even came and said: are you all right with your Mum? Other than this young lad walking by, I never spoke to anybody. Nobody came and said: could you do with a drink or anything? There was nothing there.' (Relative, Independent Inquiry Report, Volume 1, par312, p.138)
Withdrawn or self-absorbed	'I had problems with the staff there, they seemed more interested in checking their nails and mobile phones than the patients.' (Relative, Public Inquiry, Anonymised Relative 01 Witness Statement, par58, p.18)
Withdrawn or self-absorbed	'Some people, including in the portering department, are just waiting to see their time out.' (Other Employee, Independent Inquiry Report, Volume 1, par83, p.170)
Withdrawn or self-absorbed	'..there was a degree of hostility and suspicion of other organisations ……. and an unwillingness to engage with other organisations.' (Senior Executive, Public Inquiry, Anonymised Employee 01 Witness Statement, par84)
Inattentive or Distracted	'Clinical staff appeared disengaged.' (Senior Executive, Public Inquiry, Anonymised Employee 02 Witness Statement, par66)
Inattentive or Distracted	'Nurses came and went but none of them seemed to want to look patients in the eye.' (Patient, Public Inquiry, Anonymised Patient 02 Witness Statement, 4a, p.3)
Inattentive or Distracted	'Some of them were simply not interested in doing anything other than what they perceived to be their day job.' (Senior Executive, Public Inquiry, Anonymised Employee 06 Witness Statement, par101, p.32)
Inattentive or Distracted	'On one occasion, when his nutrition tube became blocked it went unnoticed until his wife informed a nurse.' (Relative, Independent Inquiry Report, Volume 2, p.32)
Inattentive or Distracted	'Staff failed to monitor her fluid levels and it was left to her family to highlight when her fluid levels became alarming.' (Patient, Independent Inquiry Report, Volume 2, p.73)
Inattentive or Distracted	'When the patient was dying, no staff came to see or check on her condition and she was left to die on a noisy ward with visitors coming in and out. Not one member of staff noticed when the patient died. It was left to her daughter to check her mother's pulse, inform staff of the death and ask for her monitor to be turned off.' (Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.65)
Inattentive or Distracted	'Later we found out from one of the other patients (this patient had been a nurse and had helped Mum – I never found out her name) that the staff had just ignored Mum for most of the earlier part of that day. She had been slumped down and unresponsive but they had just delivered and collected

	breakfast and delivered dinner without bothering with her. It was only when they collected dinner that they realised that something was wrong.' (Relative, Public Inquiry, Anonymised Relative 07 Witness Statement, par26, p.6)
Inattentive or Distracted	'….the nurses never spoke. They didn't know how to behave socially, I don't think. They spoke to one another though, having said that. They would carry on conversations over your head but they would never once acknowledge you. You were an absolute pain because – I used to get there at about 9.15, 9.30 every morning, and I always asked permission to go on to [the ward] – is it convenient for me to go on to the ward to stay with [my husband]? I sat, held his hand and wiped his face and his hands and washed his mouth. Just there to comfort him and do whatever I could. But they didn't hide the fact that they didn't like me being there.' (Relative, Independent Inquiry Report, Volume 1, par206, p.110)
Apathetic	'I doubt being a whistleblower would have achieved anything.' (Doctor, Public inquiry, Anonymised Employee 18 Witness statement, par52, p.14)
Apathetic	'…there was a poor culture for reporting incidents which seemed inherent across the organisation as a whole…….People felt that something actually had to happen i.e. someone would have to fall to classify as an incident.' (Manager, Public Inquiry, Anonymised Employee 09 Witness Statement, par23, p.8)
Apathetic	'I saw grown men crying because they had wet themselves. The attitude on the ward was that it just did not matter.' (Relative, Public Inquiry, Anonymised Relative 01 Witness Statement, par27, p.8) BETTER?
Apathetic	'I took the path of least resistance.' ' (Doctor, Public Inquiry, Volume 1, par2.138/ 2.141, p.176/77)
Resigned	'There was a sense that nothing would ever be achieved by attempting to raise or report concerns.' (Senior Executive, Public Inquiry, Anonymised Employee 04 Witness Statement, par28, p.8)
Resigned	'…there remained a group of clinical and health care staff whose general attitude appeared to be to be that there was no point reporting problems as nothing would be achieved.' (Other employee, Public Inquiry, Anonymised Employee 08 Witness Statement, par50, p17).
Resigned	'I would sometimes be discussing a patient with colleagues who would say things like "are they not going to die anyway?".' (Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par47, p.14)
Disengaged	'I noticed that there appeared to be a general lack of engagement between the management and the senior clinicians due to the fact that the clinicians were feeling disenfranchised.' (Doctor, Public Inquiry, Anonymised Employee 17 Witness Statement, par11, p.4)
Disengaged	'Clinical staff appeared disengaged.' (Senior Executive, Public Inquiry, Anonymised Employee 02 Witness Statement, par66)

12.17 Appendix 14b: Affective Detachment

Affective Detachment Narratives	
ELEMENTS	**NARRATIVE SAMPLES**
Indifferent or unconcerned	'…..when he went into hospital, we just got the impression: well, he is an old man, he is 80, it is not as if he has got a lifetime ahead of him, so why worry.' (Relative, Public Inquiry, Patient A Relative Witness Statement, p.129)
Indifferent or unconcerned	'Her false teeth were lost and the patient was not able to eat, but nursing staff were not concerned.' (Patient, Independent Inquiry Report, Volume 2, p.120)
Indifferent or unconcerned	'In the hospital the nurses showed no concern that the patient was unable to eat.' (External organisation, Independent Inquiry Report, Volume 2, p.139)
Indifferent or unconcerned	'I know I am nobody and it doesn't matter, but, surely, courtesy… nobody even came and said: are you all right with your Mum? Other than this young lad walking by, I never spoke to anybody. Nobody came and said: could you do with a drink or anything? There was nothing there.' (Relative, Independent Inquiry Report, Volume 1, par312, p.138)
Indifferent or unconcerned	'In the hospital the nurses showed no concern that the patient was unable to eat.' (External organisation, Independent Inquiry Report, Volume 2, p.139) CONCERN MOVE
Indifferent or unconcerned	'…..the doctor was not so caring upon informing her partner of her prognosis, simply saying she "was severely brain damaged and expected to die sooner rather than later". When the patient contracted a chest infection her doctor initially refused to treat her, but reluctantly prescribed antibiotics at her partner's request. She did recover and her neurological condition improved, allowing her to communicate through blinking. The doctor's behaviour remained detached, only assessing the patient for a few seconds from the bottom of her bed.' (Relative, Independent Inquiry Report, Volume 2, p.191).
Indifferent or unconcerned	'A healthcare assistant came into the room, didn't acknowledge us at all. She just walked in with a tray...she just put down the meal and just walked out the room again…About 15 minutes later, the healthcare assistant came in and just picked up the meal – the film was still on it – and just went to take it away and I said: she hasn't touched her food. She says: she never does; and just walked out.' (Relative, Independent Inquiry Report, Volume 1, par119, p.86)
Uncompassionate or uncaring	'Whenever I met with her, she was quite challenging in her approach and certainly did not give us any support or show any compassion.' (Relative, Public inquiry, Anonymised Relative 07 Witness statement, par30, p. 7)
Uncompassionate or uncaring	'The doctor demonstrated little concern or interest and, despite her mother's weight having ballooned and her condition having changed significantly, he did not appear to recognise or respond to these changes.' (Relative, Independent Inquiry Report, Volume 1, p.44)
Uncompassionate or uncaring	'The patient was concerned that the receptionist "who couldn't have cared less" was permitted to make clinical judgements about patients.' (Patient, Independent Inquiry Report, Volume 2, p.247)

Uncompassionate or uncaring	'There was no compassion from the nurses. I remember one day he called a nurse to go to the toilet. Her response was that she was looking after four other beds and was not able to help. Those four patients were asleep and I said that surely she could help. She begrudgingly said "go on then".' (Relative, Public Inquiry, Anonymised Relative 12 Witness Statement, par,12 p.4)
Uncompassionate or uncaring	''They had no business being nurses. They had no compassion, no love for the human race as a whole.' (Relative, Public Inquiry, Anonymised Relative 11 Witness Statement, par52, p.15)
Uncompassionate or uncaring	'a lack of compassion was notable amongst the nursing staff on [REMOVED].' (Relative, Independent Inquiry Report, Volume 2, p.295)
Uncompassionate or uncaring	'It was lack of anything; compassion; nobody ever came in to see Mum and just say: how are you [name]? Which my Mum used to love. ….. … She liked a bit of fuss actually, if I am honest. But no, no compassion whatsoever.' (Relative, Independent Inquiry Report Volume 1, par274, p.128)
Uncompassionate or uncaring	'And I looked at this doctor holding my mother's head and I said: this is my mother. As cold and as calculated as anything, her retort as fast as anything was: I have got a mother too. There was no compassion in that woman whatsoever.' (Relative, Independent Inquiry Report, Volume 1, par54, p.65)
Callous, Cruel or Insensitive	'She said that the staff would come and switch off the bell and tell her husband to hold on.' (Relative, Independent Inquiry Report, Volume 2, p.301)
Callous, Cruel or Insensitive	'Eventually the doctor came out and said he needed to speak to me and took me into a side room. He told me that mum's prognosis was poor and that I should sign a "do not resuscitate" form. I told him that I was sorry but I couldn't do that as I was not prepared to give up on her, even though it appeared the doctors had.'(Relative, Public Inquiry, Anonymised Relative 19 Witness Statement One, par22, p.9)
Callous, Cruel or Insensitive	'The doctor repeated himself and again said that mum would die a painful death. He said she would die "just like that" as he clicked his fingers. I simply couldn't believe his attitude.'(Relative, Public Inquiry, Anonymised Relative 19 Witness Statement One, par22/3, p.9)
Callous, Cruel or Insensitive	'I referred to him as "Doctor Death" because of his callous attitude towards the older patients on the ward.' (Relative, Public Inquiry, Anonymised Relative 19 Witness Statement One, par23, p.9)

12.18 Appendix 15: Avoidant Practices

User Need Avoidance Narratives	
ELEMENTS	**NARRATIVE SAMPLES**
Avoiding Situations	'It was difficult to obtain information from staff, who her husband believed, would "disappear at visiting times".' (Relative, Independent Inquiry Report, Volume 2, p.34)
Avoiding Situations	'On seeing the consultant in the corridor, they recalled that he hid in a linen cupboard to avoid, in their view, having to discuss her husband's case further.' (Relative, Independent Inquiry Report, Volume 1, par296, p.134)
Avoiding Situations	'His family tried to find out about his treatment but there was a lack of staff on the ward to ask and on one occasion a nurse refused to leave her office to speak to the family.' (Relative, Independent Inquiry Report, Volume 2, p.15)
Avoiding Contact	'Nurses came and went but none of them seemed to want to look patients in the eye.' (Patient, Public Inquiry, Anonymised Patient 02 Witness Statement, 4a, p.3)
Avoiding Contact	'There were occasions where medical and nursing staff went to great lengths to avoid having to discuss issues with families.' (Inquiry Chairman, Independent Inquiry Report, Volume 1, par296, p.134)
Avoiding Contact	'There was no word for it. … particularly during the two weeks that Mum was dying, effectively, they were calling out for the toilet and they would just walk by them.' (Relative, Independent Inquiry Report, Volume 1, p.45)
Avoiding Contact	'Nursing staff rarely spoke to the patient, but when they did they rushed and did not wait for her to answer.' (External organisation, Independent Inquiry Report, Volume 2, p.273)
Avoiding Contact	'…..although there were staff present on the ward, they seemed to be rushing around.' (Relative, Independent Inquiry Report, Volume 2, p.290)
Avoiding Contact	'There was very little that she could do and we feel the food was just put there and left and nobody sort of cajoled her.' (Relative, Independent Inquiry Report, Volume 1, par121, p.87)
Avoiding Contact	'REMOVED] described them as being extremely busy and constantly running around.' (Relative, Independent Inquiry Summary of Oral Evidence, Week 3)
Avoiding Contact	'…although there were staff present on the ward, they seemed to be rushing around and the ward itself felt neglected.' (Relative, Independent Inquiry Summary of Oral Evidence, Week 1)
Terminating Contact	'[REMOVED] recalls that on completing the examination the doctor left without saying anything to the patient or his wife.' (Relative, Independent Inquiry, Summary of Oral Evidence, Week 3)
Terminating Contact	'The patient informed the doctor she had no family and lived alone; his response was to shrug his shoulders and walk away.' (Patient, Independent Inquiry Report, Volume 2, p.196)
Terminating Contact	'When he questioned a nurse, he was looked at in a way to suggest, "Why are you bothering us?".' (Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.80)
Terminating Contact	'…although I was told they were encouraging her to eat, I stood back and watched the encouragement and they sort of came along: […] do you want anything to eat? She would say no and they would put the lid on and walk away.' (Relative, Independent Inquiry Report, Volume 1, par126, p.88)

12.19 Appendix 16: Deterrent Practices

User Need Deterrence Narratives	
	NARRATIVE SAMPLES
Unwelcoming	'[REMOVED] and [REMOVED] said that they felt intimidated by many of the staff and that they were unapproachable.' (Relatives, Independent Inquiry Summary of Oral Evidence, Week 2)
Unwelcoming	'The following day [REMOVED] attended the [REMOVED] at Stafford Hospital. [REMOVED] said that she saw a nurse who was very off hand and told them they had to go via [REMOVED].' (Relative, Independent Inquiry, Summary of Oral Evidence, Week 2)
Unwelcoming	'When the patient asked for assistance in breast-feeding a nurse curtly replied "don't ask me about breast-feeding; I only have cats and dogs".' (Patient, Independent Inquiry Report, Volume 2, p.187)
Unwelcoming	'Her daughter found that the staff were very uncommunicative about her mother's condition and extremely abrupt.' (External Organisation, Independent Inquiry Report, Volume 2, p.131)
Discourteous or Disrespectful	'when she attended the [REMOVED], the nurse was abrupt and bad mannered.' (Patient, Independent Inquiry Report, Volume 2, p.270)
Discourteous or Disrespectful	'A junior doctor was rude to the family who were then informed that their mother had died.' (Relative, Independent Inquiry Report, Volume 2, p.177)
Discourteous or Disrespectful	'She felt that the nurse mocked her concerns and she was made to feel she was wasting hospital time.' (Patient, Independent Inquiry Report, Volume 2, p.22)
Discourteous or Disrespectful	'Some of the staff were caring but others had a brusque manner.' (Relative, Independent Inquiry Report, Volume 2, p.188)
Discourteous or Disrespectful	'She felt that the nurse mocked her concerns and she was made to feel she was wasting hospital time.' (Patient, Independent Inquiry Report, Volume 2, p.22)
Discourteous or Disrespectful	'When she asked staff about his fall, a nurse curtly responded, "we have had a man in here with no legs and he did not fall off the bed".' (External Organisation, Independent Inquiry Report, Volume 2, p.195)
Discourteous or Disrespectful	'She observed patients being antagonised by the nurses who were rude and dismissive.' (Patient, Public Inquiry Report, Volume 2, p.22)
Threatening	'On a daily basis, [REMOVED] asked to see a doctor. She eventually confronted a nurse about the fact that she had not seen a doctor and the nurse threatened to evict her from the ward.' (Relative, Independent Inquiry Report, Volume 2, p.301)'
Threatening	'…the receptionist told her 'that if she refused to wait her turn she would be removed from the hospital'.' (Relative, Independent Inquiry Report, Volume 2, p.54)
Threatening	'My mother told me not to say anything because she would still be there after we had gone home, and was scared the nurses would be mean to her.' (Relative, Independent Inquiry Report, Volume 2, p.151)
Threatening	'Some of them were so stroppy that you felt that if you did complain, that they could be spiteful to my Mum or they could ignore her a bit more.' (Patient, Independent Inquiry Report, Volume 1, par7, p.153)

12.20 Appendix 17: The Four Hour Waiting Time Target

Four Hour Waiting Time Target Narratives	
Elements	**Narrative Samples**
Targets Norms	'Nurses were expected to break the rules as a matter of course in order to meet targets, a prime example of this being the maximum four-hour wait time target for patients in [REMOVED].' (Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par8, p.3.)
Targets Norms	'Rather than "breach" the target, the length of waiting time would regularly be falsified on notes and computer records.' (Nurse, Public Inquiry, Anonymised Employee 23 Witness Statement, par8, p.3.)
Targets Norms	'As a result of each patient in the [REMOVED] having to be seen within four hours of arrival at [REMOVED], patients were moved to any bed that could be found to avoid there being a breach of the 4 hour target. This was even if the bed that had been found was not the most suitable for the patient….. some patients were moved up to four times in a 24 hour period.' (Nurse, Public Inquiry, Anonymised Employee 13 Witness Statement, par84, p.23)
Targets Norms	'To prevent patients "breaching", the nurses would move them when they got near to the 4 hour limit and place them in another part of the Hospital. ….The overriding concern of the [REMOVED] was to get patients out as soon as possible.' (Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par14, p.4)
Targets Norms	'….a patient had been moved by someone in [REMOVED] to a ward without the knowledge of the medical staff on duty and without adequate venous access. The patient subsequently died. I had concerns that the move was the result of a decision made by someone in [REMOVED] because the patient had not been dealt with within the target 4 hours.' (Doctor, Public Inquiry, Anonymised Employee 18 Witness Statement, par10, p.3)
Targets Norms	'One example was given of when a doctor was asked to work in "minors". At the time the doctor was administering thrombolysis to a patient who had suffered a heart attack. This doctor refused but was worried that a more junior doctor might have felt compelled to comply.' (Employees, Healthcare Commission Report, p.49)
Targets Pressure	'The pressure to comply with targets was huge.' (Manager, Public Inquiry, Anonymised Employee 09 Witness Statement, par34, p.12)
Targets Pressure	'Many staff that we interviewed volunteered their view that the approach of the trust meant that the care of patients had become secondary to achieving targets and minimising breaches. Doctors considered that the prioritisation of the patients with minor ailments led, on occasions, to a distortion of clinical priorities. Middle grade doctors told us that they were asked to work with patients in the "minor" side to push these patients through, although this was at the expense of more seriously ill or injured patients. They felt pressured to prioritise patients who were close to breaching the target rather than prioritise by clinical need.' (Employees, Healthcare Commission Report, p.49)
Targets Pressure	'Both doctors and nurses told us that the pressure to meet the four-hour target forced doctors in training to make rapid decisions either to discharge or admit patients. In some instances, they were discharged inappropriately and, in others, they were admitted but without a proper plan of care.' (Employees, Healthcare Commission Report, p.49)

Targets Pressure	'The treatment by management of nurses in particular was beyond belief. The nurses were threatened on a near daily basis with losing their jobs if they did not get patients out within the 4 hours target.' (Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par10, p.3)
Targets Pressure	'I wouldn't attend the meetings myself but would see nurses going into the meeting with the bed co-ordinator and management. It was quite normal for nurses to come out at the end of these meetings crying because they had been told that if they did not meet the 4 hour targets, they would lose their jobs. This sometimes happened several times in a week.' (Doctor, Public Inquiry, Anonymised Employee 15 Witness Statement, par10, p.3)
Targets Bullying Sanctioning	'Nurses told us they felt they were in "the firing line" with regards to breaches of the target and, as such, were always being blamed.' (Nurses, Healthcare Commission Report, 2009, p.49)
Targets Bullying Sanctioning	'The pressure to meet this generated a fear, whether justified or not, that failure to meet targets could lead to the sack.' (Inquiry Chairman, Independent Inquiry Report, Volume 1, par43, p.16)

12.21 Appendix 18: The Food Routine

Food Routine Narratives
NARRATIVE SAMPLES
'Sometimes even though I had filled in the menu sheet, I didn't get a meal. Very often didn't get a meal.' (Patient, Independent Inquiry Report, Volume 1, par112, p.84)
'…..her son often found her hungry……. Her son had to buy meals from the café and then feed her himself "to prevent her [his mother] starving".' (Relative, Independent Inquiry Report, Volume 2, p.258)
'He could not hold his trousers up because of the lost weight ….. When he was admitted he was looking well and of normal weight. He was not fed for nine days.' (Relative, Public Inquiry, Anonymised Relative 12 Witness Statement, par12, p.4)
'He could not hold his trousers up because of the lost weight ….. When he was admitted he was looking well and of normal weight. He was not fed for nine days.' (Relative, Public Inquiry, Anonymised Relative 12 Witness Statement, par12, p.4)
'He was given solid food, despite being unable to eat and requiring a nutrition tube.' (External Organisation, Independent Inquiry Report, Volume 2, p.203)
'[REMOVED] had problems swallowing and was given inappropriate food to eat, for example bacon and an orange that he was unable to peel.' (Relative, Independent Inquiry Report, Volume 2, p.301)
'She was provided with a meal but it was left out of her reach and in an attempt to feed herself she caused injury to her arm.' (Patient, Independent Inquiry Report, Volume 2, p.185)
'Often his daughter attended to find his meal left on the table, her father could not eat unaided and had simply been left.' (External Organisation, Independent Inquiry Report, Volume 2, p.97)
'…..staff did not move the patient to aid her eating. It was left to family members to assist her eating.' (Patient, Independent Inquiry Report, Volume 2, p201)
'…..staff provided no help with drinking or eating and her family found that her meals were simply left by her bed.' (Relative, Independent Inquiry Report, Volume 2, p.26)
'…she often witnessed food being put out for patients who were not asked if they needed help to eat. The food was then removed untouched.' (Relative, Independent Inquiry Report, Volume 2, p.320)
'The chap next to him, he got Alzheimer's, he had got tomato soup with a lid on, he got rice pudding with a lid on, he had got sandwiches in cellophane. They can't do that when they are ill. They just can't.' (Relative, Independent Inquiry Report, Volume 1, par117, p.85)
'They were putting the glass—you know, a jug of water there. Mum couldn't see the jug of water. She couldn't see the glass to pour the fluids.' (Relative, Public Inquiry Report, Volume 2, par25.17, p.1601)
'She may have said: I don't want that. She needed encouraging because, you know, when you are ill and your palate – it needs tempting and it seems – I don't know, it seems to me as though she almost starved to death on that ward.' (Relative, Independent Inquiry Report, Volume 1, par121, p.87)
'I went in one day..... and his dinner was not on the bottom of the bed and I said: where is your dinner? And he says: she took it away. I said: why? He said: I don't know, I couldn't reach it.' (Relative, Independent Inquiry Report, Volume 1, par188, p.86)

12.22 Appendix 19: Complaints System Narratives

Complaints System Narratives	
ELEMENTS	**NARRATIVE SAMPLES**
Denying	'His family then noticed that the oxygen bag had once again gone flat. They shouted for help and they were ushered out of the room. An argument then ensued as the nurses denied that the bag had gone flat.' (Independent Case Notes Review, Independent Inquiry Report, Volume 2, p.177)
Denying	'After very rudely insinuating that I was lying throughout the meeting, [REMOVED] refuted that he had had his insulin changed saying that: "No he hasn't, no he hasn't, who told you that?' (Relative, Public Inquiry, Anonymised Relative 20 Witness Statement, par8, p.2)
Denying	'The patient was then discharged with medication in tablet form; on return home, her husband telephoned the hospital to remind them she could only take liquid medication. The nurse curtly responded that she had shown him the medication and that he had said it was suitable, but he knew this to be untrue, as he had collected the medication from the pharmacy.' (External Organisation, Independent Inquiry Report, Volume 2, p.34)
Denying	'The Consultant told us at the meeting that he had not done anything wrong and if there was anything inappropriate about [REMOVED] care, it was not his fault but that of the nursing staff.' (Relative, Public Inquiry, Anonymised Relative 09 Witness Statement, par23, p.6)
Denying	'An "overwhelming sense of denial... characterised by 'it is not our fault, it is somebody else's'".' (Board member and Senior Executive, Independent Inquiry Report, Volume 1, par214, p.347)
Denying	'I was surprised by the level of denial within some parts of the Trust. I remember the phrase "It could have happened to any hospital but we were unfortunate to be investigated" being used a lot.' (Doctor & Senior Executive, Public Inquiry, Anonymised Employee 17 Witness Statement, par9, p.4)
Denying	'…..there was a definite reluctance on the part of many members of staff to accept responsibility for their actions…..This culture of denial permeated to all levels of the Hospital.' (Senior Executive, Public Inquiry, Anonymised Employee 01 Witness Statement, par35, p.9)
Threatening or Retaliating	'….she did not want us to complain……because she said that the staff would take it out on her and she feared retaliation.' (Relative, Public Inquiry, Anonymised Relative 09 Witness Statement par12, p.4)
Threatening or Retaliating	'I overheard and I said I was going to complain. He got very, very agitated and distressed saying: don't say anything, don't say anything, they will take it out on me.' (Relative, Independent Inquiry Report, Volume 1, par17, p.54)
Threatening or Retaliating	'[REMOVED] was afraid to complain about anything because he thought that if he did he might make his stay there even more uncomfortable.' (Relative, Public Inquiry, Anonymised Relative 15 Witness Statement , par15, p.4)
Threatening or Retaliating	'He had actually complained, hadn't he, about the treatment he had received from one nurse whilst there? And as a result this nurse totally ignored him for the rest of his stay; like she would walk by the bottom of his bed, he would ask for help or a drink and she just totally ignored him.' (Relative, Independent Inquiry Report, Volume 1, par30, p.158)
Threatening or Retaliating	'He also recalls experiences of bullying by one member of staff… [REMOVED] did not complain….because he felt vulnerable and feared repercussions.' (Patient, Independent Inquiry, Summary of Oral Evidence, Week 2)